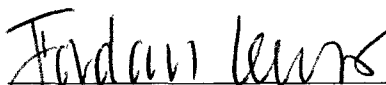


DIFFERENCES BETWEEN FREQUENCY OF DIAGNOSIS, DIAGNOSIS
EXTREMITY, AND GLOBAL ASSESSMENT OF FUNCTIONING SCORE IN A
EURO - AMERICAN AND ALASKA NATIVE CLIENT

By


Britton Ann Niles

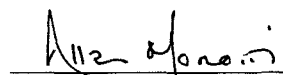
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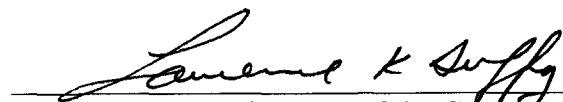

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A
THESIS

Presented to the Faculty
of the University of Alaska Fairbanks
in Partial Fulfillment of the Requirements
for the Degree of

DOCTOR OF PHILOSOPHY

By

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May 2011

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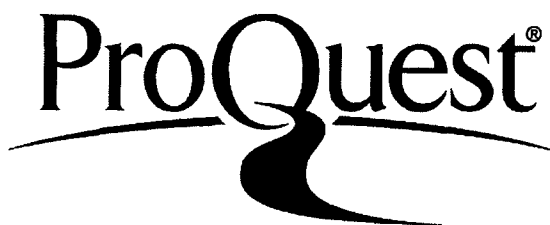
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Abstract

This research answers the question, given identical client information, history, and presenting issues, but variation in ethnicity, does diagnosis frequency, diagnosis extremity, or Global Assessment of Functioning score differ for an Euro-American male versus an Alaska Native male mental health client. Graduate counseling students, six males and six females, ranging in age from 22-59, currently enrolled at either the University of Alaska Fairbanks, the University of Alaska Anchorage, or Alaska Pacific University, volunteered to participate in the present study. Participants were randomly assigned to view either a Euro-American or Alaska Native client's mock intake session. The mock videos were identical in script and environment; the only difference in the videos is that one male actor is Euro-American and the other actor is Alaska Native. Completed mental health intake forms were compared and evaluated through both quantitative and qualitative methods. Qualitatively, Strauss and Corbin's three step analytic process, grounded theory, was used to analyze the descriptive part of the intake form. Axis I, II, III, IV and V, of the DSM-IV-TR, multi-axial system, were quantitatively, assessed to determine diagnosis differences between the Euro-American and Alaska Native client. Results identify that counseling students in training view the Alaska Native client as overall more maladaptive versus the Euro-American client. Counselors-in- training expressed this tendency through more frequent diagnosis and lower Global Assessment of Functioning scores for the Alaska Native client. These results support the need for future research and counselor training programs to be aware of these tendencies of counselors-in-training.

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Chapter One

Introduction

This research aims to respond to the need set forth by Feisthamel and Schwartz (2009) in which they identify that minimal research has been conducted regarding impact of race on diagnosis in the DSM-IV-TR and how race impacts onset, symptoms, course, diagnosis, and treatment. Currently, literature is lacking that identifies the current state of counselors-in-training and differences of diagnosis for Euro-American versus Alaska Native clients.

According to the American Psychological Association (APA) and the American Counseling Association (ACA), one aspect of cultural competence is the ability to know one's own culture and that of the client's culture. Additionally, counselors-in-training must be cognizant of cultural similarities and differences that exist between them and their client (ACA, 2005; APA, 2003). Information gleaned from this research is intended for counselors-in-training, researchers, educators, and professional counselors to consider in order to exceed the current state of culturally competent diagnosis, research, and education.

The APA and the ACA have set forth a set of ethical principles to which all-practicing counselors-in-training must uphold. Training programs must adhere to these principles set forth by the APA and the ACA, hence they must endeavor to guide their students to continually improve their cultural competence. These ethical principles serve as guidelines for effective and appropriate practices among counselors, researchers, and educators. In order to establish a

comprehensive understanding of the standards of competency among counselors, one must look at the guidelines to which they adhere, the ethics that they uphold, and the institutions they are affiliated with.

1.1 American Counseling Association-Ethics

All members of the ACA strive to embody the mission, which reads, “to enhance the quality of life in society by promoting the development of professional counselors, advancing the counseling profession, and using the profession and practice of counseling to promote respect for human dignity and diversity” (ACA, 2005, p. 1).

As stated, the ACA is primarily concerned with the continued advancement of the counseling profession, as well as the education of potential counselors. Furthermore, they are concerned with the continued fostering of respect for diversity and dignity.

In order to fully understand the role and ethics that counselors and counselors-in- training must adhere to, a brief review of the ACA’s code of ethics followed by a brief review of the APA’s code of conduct and multi-cultural guidelines will ensue. It is important to note that all sections within the ACA code of ethics identifies specific attention be paid to cultural considerations. The following is the ACA’s code of ethics, highlighting sections pertaining to culture.

Section A: The Counseling Relationship

The first section deals with the counseling relationship. This section lays out 12 main points with subsections relating to topics including, but not limited to, the

welfare of those served by counselors; informed consent in the counseling relationship; clients served by others; avoiding harm and imposing values; roles and relationships with clients and finally, roles and relationships at individual, group, institutional, and societal levels

(ACA, 2005). Section A focuses on the individual relationship that counselors have with their clients, as well as the importance of the counselors' cultural awareness.

This point is illustrated by subsection A.2.c of the ACA Code of Ethics (2005). This subsection, *Developmental and Cultural Sensitivity*, asserts

Counselors communicate information in ways that are both developmentally and culturally appropriate. Counselors use clear and understandable language when discussing issues related to informed consent. When clients have difficulty understanding the language used by counselors, they provide necessary services (e.g., arranging for a qualified interpreter or translator) to ensure comprehension by clients. In collaboration with clients, counselors consider cultural implications of informed consent procedures and, where possible, counselors adjust their practices accordingly. (ACA, 2005, p. 4)

Section B: Confidentiality, Privileged Communication, and Privacy

The second section of the ACA Code of Ethics (2005) relates to the

counselors responsibility to maintain trust and confidentiality with clients. This is illustrated in section B.1.a of the ACA Code of Ethics, “Counselors maintain awareness and sensitivity regarding cultural meanings of confidentiality and privacy. Counselors respect differing views toward disclosure of information. Counselors hold ongoing discussions with clients as to how, when, and with whom information is to be shared” (ACA, p. 4).

One part of building trust, according to the ACA (2005), is maintaining cultural sensitivity with regard to personal and sensitive matters. Counselors are urged to understand cultural differences with regard to sharing sensitive information with others. They are also expected to maintain communication with clients regarding information disclosure to ensure that appropriate conduct is maintained (ACA).

Section C: Professional Responsibility

Section C provides guidelines regarding the professional responsibilities of a counselor. Professional responsibility includes their responsibility to have knowledge of and uphold the ACA Code of Ethics (2005), in addition to their responsibility on an individual, societal, and institutional level. Practitioners are expected to know the boundaries of their competence. This statement is expressed in section C.2.a:

Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and

appropriate professional experience. Counselors gain knowledge, personal awareness, sensitivity, and skills pertinent to working with a diverse client population. (ACA, p. 9)

Members of the ACA, and practicing professionals under the ACA, are expected to participate in associations that foster and promote the continued development and improvement of counseling. Counselors are expected to maintain open and honest communication with clients and their communities that are unbiased, and to practice within their limits of competency. Furthermore, it is their responsibility to provide services that are based on scientifically researched methodologies that are culturally appropriate to those which services are rendered (ACA, 2005).

Section D: Relationships with Other Professionals

This section relates to the counselors relationships with other professionals, both in and out of the counseling field. Counselors must understand that their interactions with colleagues and other professionals have an impact on the quality and type of services they provide to their clients. Counselors are respectful of traditions and practices of other professional groups with which they work: “Counselors are respectful of approaches to counseling services that differ from their own” (ACA, 2005, p. 11). Counselors must work to develop and maintain an understanding of other professionals both within and outside the counseling professions. Furthermore, they are to maintain an open and positive relationship

with other professionals in an effort to provide and enhance services available to clients. In addition to the relationships that counselors build with other professionals, this section also includes such topics as different approaches, interdisciplinary teamwork, confidentiality, and establishing professional and ethical obligations (ACA).

Section E: Evaluation, Assessment, and Interpretation

The evaluation, assessment, and interpretation section deals with the counselor's use of assessment tools and techniques with clients. This section insists that a counselor should have proper knowledge on the appropriate use and application of different assessment tools and techniques, and should never engage in the use of an assessment or evaluation procedure or tool that he or she is not properly trained to utilize. The ACA (2005) asserts the importance of understanding cultural differences, and the effects those differences may have on the outcomes of different assessment approaches. Section E further asserts the counselor's responsibility regarding responsible use of diagnosis: "Counselors may refrain from making and/or reporting a diagnosis if they believe it would cause harm to the client or others" (ACA, section E.5.d, 2005, p. 12). This section also covers the importance of informed consent with regard to clients. Ensuring that the client is aware of the reason, process, and potential outcomes associated with assessment and evaluation procedures is important in building and maintaining trust between the client and counselor, as well as ensuring that the assessment or evaluation is appropriate (ACA).

Section F: Supervision, Training, and Teaching

Section F refers to the training, teaching, and supervision of students, counselor trainees, and other supervisees. Counselors and supervisors are to build respectful and professional relationships with those in training, and are expected to evaluate and assess progress of trainees fairly. Appropriate monitoring of counselors-in-training or students is important for ensuring the welfare of the client. When supervising another professional or individual in training, the supervisor is expected to maintain their own level of competence, as well as an understanding of the limitations and abilities of the individual in training (ACA, 2005). This is expressed in section F.2.a,” Prior to offering clinical supervision services, counselors are trained in supervision methods and techniques. Counselors who offer clinical supervision services regularly pursue continuing education activities including both counseling and supervision topics and skills” (ACA, p. 14).

In addition to the responsibilities of the trainer, section F also sets out responsibilities and guidelines for students receiving training under the ACA. Students operating under the ACA are expected to have knowledge of and uphold the ACA Code of Ethics (2005). They are also expected to maintain an understanding of their personal abilities, and are to refrain from engaging in counseling activities when they are emotionally, physically, mentally, or otherwise impaired and unable to provide services (ACA).

Section G: Research and Publications

Counselors conducting research are to adhere to the guidelines set forth by the ACA. Section G discusses the necessary steps to be taken in order to design, implement, report, and publish research. Researchers are to conduct their investigations in such a manner as to avoid harm and injury, maintain respect for cultural diversity, and implement minimal interference. Furthermore, counselors conducting research are to do so in an empirical, rigorous, and documented manner (ACA, 2005).

As section G.2.d explains, research that involves the use of participants must include an informed consent, confidentiality information, debriefing, and appropriate storage and disposal of confidential documentation:

Counselors conducting research involving clients make clear in the informed consent process that clients are free to choose whether or not to participate in research activities. Counselors take necessary precautions to protect clients from adverse consequences of declining or withdrawing from participation (ACA, 2005, p. 17).

With regard to reporting findings from research endeavors, counselors are to report accurately, including unfavorable results and errors, while maintaining the confidentiality of participants (ACA).

Section H: Resolving Ethical Issues

The final section of the ACA Code of Ethics (2005) focuses on resolving ethical issues. The ACA holds that it is the counselor's responsibility to behave in a professional and ethical manner at all times, as well as to hold other professionals to the same standards to which he or she adheres, including taking necessary action when these standards may not be upheld. Counselors are to maintain the protection and trust of their clients at all times through professional and ethical behavior: "Counselors expect colleagues to adhere to the *ACA Code of Ethics*. When counselors possess knowledge that raises doubts as to whether another counselor is acting in an ethical manner, they take appropriate action" (ACA, section H.2.a, p.19). Ethical issues are to be dealt with in a professional manner, maintaining open communication with all parties involved. This section also outlines the proper steps to be taken in the event that an ethical issue needs to be resolved, including cases of informal resolution, reporting ethical violations, organizational conflicts, and unwarranted complaints (ACA).

By exploring the ACA Code of Ethics (2005), one can conclude that the relationship between the counselor and the client are top in priority with regard to counseling competence. Moreover, the ACA maintains that the protection of all individuals involved in the counseling process is important. Maintaining confidence and confidentiality are paramount to building trust, maintaining open communication, and promoting positive growth and a healthy lifestyle. Professional responsibility goes hand in hand with the first two principles. The

ACA maintains that as a professional in the mental health field, counselors have an obligation to maintain the ACA standards, as well as to promote health within their cultural clients.

1.2 American Psychological Association-Code of Conduct

The APA has a set of governing standards known as *The Ethical Principles of Psychologists and Code of Conduct* (2002). Hereby referred to as the APA's Codes of Conduct, this document outlines appropriate behaviors and responsibilities on the part of psychologists, as well as other professionals in the mental health profession. Since its adoption in 1953, the APA's code of conduct has gone through nine revisions, the most recent occurring in 2002, implemented in 2003. The APA's codes of conduct reflect the mission and vision statements of this association. As stated, the APA is concerned with the continued advancement and application of psychological knowledge for the benefit and continued improvement in the lives of individuals and society. To further understand the motivation behind this association, an examination of their vision statement is also necessary. The APA outlines their vision statement in seven leading points:

- A uniting force for the discipline;
- The major catalyst for the stimulation, growth and dissemination of psychological science and practice;
- The primary resource for all psychologists;
- The premier innovator in the education, development, and training of psychological scientists, practitioners and educators;

- The leading advocate for psychological knowledge and practice informing policy makers and the public to improve public policy and daily living;
- A principal leader and global partner promoting psychological knowledge and methods to facilitate the resolution of personal, societal, and global challenges in diverse, multicultural, and international contexts; and
- An effective champion of the application of psychology to promote human rights, health, wellbeing, and dignity. (About APA, 2009, p. 1)

The APA's Codes of Conduct (2002) are outlined under five general principles and contain 10 ethical standards of professional behavior. According to the APA, the five general principles do not represent enforceable rules, but are instead designed as considerations that psychologists should take into account when arriving at ethical decisions. The five general principles are beneficence and nonmaleficence; fidelity and responsibility; integrity; justice; and respect for people's rights and dignity (APA).

By examining the APA's Code of Conduct, one is able to derive an understanding for the values and beliefs held by this association and its members. The APA further identified a need to set forth the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists*, which further explores counseling endeavors with multi-cultural populations (APA, 2003). The following is a synopsis of the APA's Multicultural Guidelines, which support the nature of this research.

1.3 American Psychological Association Multicultural Ethical Guidelines

The APA's (2002) *Ethical Principles of Psychologists and Code of Conduct* states explicitly that psychologists must attend to cultural, individual, and role differences related to age, gender, race, ethnicity, and national origin if they are to provide appropriate services to a culturally diverse population. While the APA sets forth a set of ethical codes, they additionally set forth a document entitled the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA, 2003). The APA states that these guidelines are an attempt to address multicultural populations, and that it is impossible to include a complete comprehensive review of all literature related to the multifaceted layers of culture within all cultures, and multicultural individuals and populations (APA).

This document identifies that multicultural best practices occur in a hierarchical fashion. At the base level, guideline 1, the APA asserts that the professional must have "knowledge of self with a cultural heritage and social varying identities" (2003, p. 3). This means in order to be an ethical multicultural professional, one must embark on the quest of knowing and understanding themselves. As Rogers (1989) states, *On Becoming a Person* text:

The self-awareness and human presence of the therapist is more important than the therapist's technical training. And the boundary between psychotherapy and ordinary life is necessarily thin. If acceptance, empathy, and positive

regard are the necessary and sufficient conditions for human growth, then they ought equally to inform teaching, friendship, and family life (Rogers, p. xii).

A continuum exists for counselors who identify as Euro-American or non-Euro-American value oriented. Livingston et al. (2008) identify eight categories in which Euro-American culture differs from non Euro-Americans, according to common values. Euro-American values include “small family units, independence emphasized in child rearing, competition fostered in group relationships, youth valued and respected, flexible boundaries between gender roles, future oriented, individuality emphasized, implement rational and scientific explanations regarding spirituality and religion” (Livingston et al., p. 10).

Upon effective reflection of one’s self, professionals can then move to the second level within the hierarchy, guideline 2, which for the APA (2003) concerns knowledge about other cultures. Livingston et al. (2008) note that non-Euro-American populations have varied value orientations from Euro-Americans. Non-Euro-American values are reported to be, “High value of extended family networks, sharing emphasized in child rearing, cooperation fostered in group relationships, strict boundaries between gender roles, past- oriented, teamwork emphasized, and spiritual and magical explanation related to spirituality and religion (Livingston et al., p. 10).

Culturally competent counseling professionals must be aware of multicultural constructs that influence cultural identities. Wolsko, Lardon, Hopkins and Ruppert (2006) exemplify this point in the text *Conceptions of Wellness among the Yup'ik of the Yukon-Kuskokwim Delta: The Vitality of Social and Natural Connection*, which discusses Alaska Native culture. Alaska Natives conceptualize optimal experience in the following way: “optimal experience of personhood is inextricably linked with one’s place in space, with one’s social and natural context, and the sense that walking the path of wellness is a matter of maintaining the proper harmony in one’s relationships” (Wolsko et. al., p. 346). In order for a counselor to effectively understand and provide culturally competent services, they must be able to understand and incorporate the client’s worldview into the therapeutic process. A worldview according to Koltko-Rivera (2004) is “a set of assumptions about physical and social reality that may have powerful effects on cognition and behavior” (Koltko-Rivera, p. 3).

On the third level, the APA identifies Guideline 3: “As educators, psychologists are encouraged to employ the constructs of multiculturalism and diversity in psychological education” (2003, p. 10). Cartwright and D’Andrea (2005) conducted an interview with Paul Pedersen, discussing the culture-centered counseling training framework that provides a three level competency structure for educators to consider. The three levels of competency are interconnected: awareness, knowledge, and skill. Additionally, these three components are identified in the conceptual framework of multicultural

counseling training. It is crucial to note that under emphasizing or over emphasizing any of these three components can result in a lack of *I* awareness and knowledge of multicultural clients (Cartwright & D'Andrea).

This culturally-centered model enables students to achieve competency, while supporting an in depth understanding of the complexity of various cultures. Pedersen discusses that the benefits of his culture-centered perspective provides mental health professionals with, “accuracy, common ground for conflict management, identity, health through biodiversity, protection from cultural encapsulation, future survival in the global village, social justice, right thinking that is both linear and nonlinear, culture shock learning, spirituality, political pluralism, and good psychology” (Pedersen, as cited in Cartwright & D'Andrea, 2005, p. 218).

The APA's fourth level pertains to research: “Guideline 4: Culturally sensitive psychological researchers are encouraged to recognize the importance of conducting culture-centered and ethical psychological research among persons from ethnic, linguistic, and racial minority backgrounds” (2003, p. 11). Gushue, Constantine, and Sciarra (2008) discuss that researchers have been endeavoring to include multi-cultural frameworks into research for many decades. In addition, Norton and Manson (1996) indicate that researchers should consider the role tribes play, procedures for human participants, individual and community participation, differences in confidentiality, and the concept of benefit when working with Alaska Native populations.

“Guideline 5: Psychologists are encouraged to apply culturally appropriate skills in clinical and other applied psychological practices” (APA, 2003, p. 12).

Once the counselor has identified the clients presenting concern, they must consider and choose the best treatment option for their client. Counselors should consider evidence-based practices when those are the best fit for their client (Kazdin, 2008). Gone and Alcantara (2007) find that a review of the literature yields 56 articles related to Native-specific mental health. Counselors working with American Indian or Alaska Native populations certainly should endeavor to read the body of science set forth to best serve their clients needs.

“Guideline 6: Psychologists are encouraged to use organizational change processes to support culturally informed organizational (policy) development and practices” (APA, 2003, p. 13). Whealin and Ruzek (2008) identify 10 ways that mental health providers can assess and improve their organization’s cultural responsiveness:

- (1) Obtain organizational support;
- (2) Review and update mission and policies;
- (3) Improve staff’s knowledge about community populations;
- (4) Evaluate and enhance staff’s cross cultural skills;
- (5) Build cultural diversity among staff;
- (6) Assess client needs and beliefs;
- (7) Adapt procedures, infrastructure, and physical environment;
- (8) Facilitate verbal and written communication;

- (9) Collaborate with spiritual leaders and traditional healers; and
- (10) Evaluate findings, identify goals, and disseminate recommendations.

The APA's Multicultural Guidelines (2003) clearly identify the ethics that facilitates cultural competence for mental health providers. These guidelines support knowing and understanding culture through the client's lens, as well as through the counselor's cultural lens. Developing an understanding of the similarities and differences that exist between cultures, as well as an understanding of how those viewpoints affect one another, is an important part of cultural competence.

By examining the APA's (2002) and the ACA's (2005) code of ethics and the APA's code of conduct and multicultural guidelines (2003), it is apparent how these organizations influence service providers. The APA and the ACA offer the skeletal framework--values, guidelines, ethics, and goals--which guide professionals in the pursuit of being a competent multicultural counselor. All counselors, including counselors-in-training, must ethically adhere to the standards set forth by these organizations the inability to do so is a core violation of their profession's ethics.

The rationale for this research stems from phenomena discussed by Baron, Byrne, and Branscombe, (2006) and many others, such as bias, stereotypes, white privilege, and prejudice. Furthermore, this research identifies how these concepts influence diagnosis and treatment for counselors-in-training. This research

identifies if and how counselors- in-training differ in offering a diagnosis of an Alaska Native client versus a Euro- American client.

Counselors-in-training aiming to provide culturally competent services to clients must be aware of their values and beliefs. Arguably, explicit assumptions represent an area, which the counselor trainees must be aware of, as explicit assumptions may influence diagnosis, assessment, and the treatment choices made by them. Furthermore, counselors-in-training must explore what belief systems and/or judgments they identify or experience when they visually experience a client whose ethnic origin differs from their own: it seems what is seen often informs us first.

Counselor trainees can benefit from considering Yamada and Brekke's (2008) perspective, in which they support that counselors must endeavor to understand wellness and balance through their clients' sociocultural lens. This means counselors-in-training must hone their abilities to understand their own cultural lens, in order to ensure that they are able to remove it in order to facilitate the improved cultural functioning of their client, based on the cultural self the client desires to manifest. Cultural self refers to the clients identified culture and the values, beliefs and daily experiences they desire to achieve, within their cultural framework.

The goal of the current study was to identify differences existing in diagnosis, diagnosis extremity, and GAF scores when counselor trainees are presented with a mock intake session that is scripted and filmed in the exact same

way. The variable that differed in the mock mental health intake session was whether the client was a Euro-American male or an Alaska Native male.

The quantitative hypothesis was that with all else being equal, counseling students would perceive an Alaska Native client as more maladaptive than the Euro-American client, as expressed by more frequent diagnoses, more extreme diagnoses, or lower GAF scores. The quantitative null hypothesis was that there would be no difference in the frequency of diagnosis, intensity of diagnosis, or GAF scores given to otherwise identical Alaska Native and Euro-American clients.

This research identifies useful information that will benefit Alaska Native and Euro-American peoples, educators, researchers and counselors-in-training. Counseling methods and techniques are implemented to assist clients in emotional, psychological, physical, and social wellness. Counselor trainees have many different considerations to take into account as a means to uphold ethical principles and facilitate a productive relationship with clients in multicultural counseling practices.

In order to address the areas noted previously in this chapter, chapter two further discusses cultural awareness, counselors-in-training, explicit assumptions and attitudes, visual and behavioral considerations, both generally and specifically related to Euro-American and Alaska Native culture, language, social support, diagnosis, and treatment. Chapter two discusses these concepts as they represent areas that may influence the provision of culturally competent services by

counselors-in-training. It is important to remember that both the APA (2003) and the ACA (2005) identify that counselors must understand their clients cultural self, as well as their own cultural lens, as the clients and counselors cultural lens impacts every perception, action, and cognitive processes experienced.

1.4 Definitions of Terms

In an attempt to minimize miscommunication, the following terms utilized throughout this manuscript are defined as follows:

- ☐ Alaska Native- An individual who self identifies as an Alaska Native.
- ☐ American Counseling Association (ACA)- A not for profit organization that works to improve the counseling profession in education, research, training, and practice (ACA, 2005).
- ☐ American Psychological Association (APA)- An organization that works to improve the field of psychology in education, research, training, and practice (APA, 2009).
- ☐ AXIS I- Clinical disorders and other conditions that may be a focus of clinical attention are identified on this axis. An example of a clinical disorder is Tourettes Disorder (APA, 2000).
- ☐ AXIS II- Personality disorders and mental retardation are identified on this axis. An example of a personality disorder is Bi-polar disorder (APA, 2000).
- ☐ AXIS III- General medical conditions are identified on this axis. An example of a general medical condition is back pain (APA, 2000).

- AXIS IV- Psychosocial and environmental problems are identified on this axis. An example of an environmental problem is a client is evicted from their residence (APA, 2000).
- AXIS V- Global Assessment Functioning Score (GAF)- A scale set forth in the DSM-IV-TR, 2000, which counselors implement to identify the overall functioning of their client. GAF scale ranges from 1-100 (APA, 2000).
- Colorblindness- A denial of differences (Ming Liu, Pickett, and Ivey, 2007).
- Culture- “A learned system of meaning and behavior passed from one generation to the next” (Gerstein, Rountree, & Ordonez, 2007).
- Ethnocentric monoculturalism- “The invisible veil, of a worldview, that keeps white Euro- Americans from recognizing the ethnocentric basis of their beliefs, values, and assumptions” (Sue, 1999, p.).
- Euro-American- An individual who self identifies as a Euro-American.
- Multi-axial diagnostic system- The multi axial diagnostic system, according to the DSM-IV-TR, enables counselors to assess their clients over multiple domains (APA, 2000).
- Prejudice- “the affective component, or feeling, we have about particular groups.” (Baron et al., 2006, p. 213).
- Stereotypes- “beliefs about social groups in terms of the traits or characteristics that they are deemed to share” (Baron et al., 2006, p. 213).

Chapter Two

Cultural Awareness and Cultural Counseling

It is important to reiterate that both the APA and the ACA identify that counselors and counselors-in-training must understand their clients cultural self, as well as their own cultural lens, in order to execute culturally competent counseling endeavors. The ethical requirements to know oneself and that of your client leads to the discussions set forth in this chapter; this research is based on these phenomena, as it is theorized that the forth- coming concepts may impact counselors-in-training, diagnosis, extremity of diagnosis, and GAF scores for Euro-American and Alaska Native clients.

This chapter begins by discussing cultural awareness, which includes knowing oneself, and knowing another's culture, that of the client, in this situation. Discussion continues by exploring Euro-American culture and the history of Euro-American culture, thus leading to further discussion of explicit assumptions, prejudice, and stereotypes that counselor trainees may experience, as these assumptions may influence the diagnosis they provide for the Euro-American and Alaska Native clients. Visual, behavioral, and language considerations are discussed as they highlight similarities and differences graduate students may experience, which may influence the diagnosis of their respective clients. This chapter continues with a discussion of Alaska Native culture and history. Language is discussed as it relates to Euro-American language and its history, as well as language as it relates to the Alaska Native

experience. Social support is discussed also through the lens of Euro-American social strategies and Alaska Native social strategies. This chapter concludes with a discussion of the cultural considerations for counselors-in-training when diagnosing, implementing assessment tools, and treating Euro-American and Alaska Native populations.

2.1 Cultural Awareness

Counseling methods and techniques are utilized to assist all clients in matters pertaining to their emotional, psychological, physical, and social wellbeing. One aspect of cultural competence is the ability to understand the importance of being aware of one's own culture, as well as the culture of the client who the counselor-in-training aims to serve. In addition to this, counselor trainees must be cognizant of cultural similarities and differences that exist and how those may impact the counseling process.

It would appear that knowing oneself or another is a simple task. On closer examination, the students may discover that in order to provide culturally competent services one must understand their personal cultural lens, which includes both development and practice, which impacts every perception, action, and cognitive process the counselor-in-training experiences. Next, the provider must endeavor to understand and experience knowledge and understanding of their client's culture. What at first seemed simple, at second glance seems to be a life long process that must be honed continuously during the educational process and practiced in all therapeutic endeavors.

Culturally competent mental health providers apply therapeutic techniques that facilitate the client's expression of their cultural values and an exploration of what cultural wellness looks and feels like to them. For the trainee, at times this may mean working with Euro-American or Alaska Native clients towards a cultural wellness that may be different than their own culture. If mental health providers do not implement culturally competent practices, misdiagnosis, inaccuracy of extremity of diagnosis, and inaccurate GAF scores may occur for clients.

Gerstein, Rountree, and Ordonez, (2007) identify that the definition of culture most scholars utilize is “ a learned system of meaning and behavior passed from one generation to the next”(p. 13). Counselors-in-training must recognize that clients may be assessing cultural similarities and differences based on many components including age, gender, sexual orientation, race, disability, and socioeconomic status, to name a few (Leuwerke, 2005).

The historical development of ethnic experience in Euro-American history can be visualized as a pendulum. An examination of Euro-American history identifies that discrimination has occurred and efforts have been made to minimize discrimination. As recent as 50 years ago, ethnicity was a dominant theme, the pendulum in flux. During the 1960s varying opinions were expressed in a myriad of expressions: crosses being burnt, segregation in public and private forums, and disparate access to educational opportunities, to offer a few examples. For some, it appears that the conceptualizations of race have swung in

the opposite direction on the pendulum, and some counselor trainees may be implementing a colorblind approach.

Ming Liu, Pickett and Ivey (2007) note that White Middle-Class Privilege can be present in the counseling experience. Furthermore, Ming Liu et al. support that when appropriate white middle class privilege should be discussed during the counseling process (p. 203). Counselor trainees, who implement a colorblind strategy, are denying that racial identification or discrimination occurs, which may enable them to operate under the false illusion that equality exists. Ignoring or minimizing the experience of racism and discrimination in minority groups' day-to-day lives, however, enables Euro-Americans to turn a blind eye to the benefits bestowed upon them by the mere fact that they are Euro-American.

In the book, *Multicultural Social Work Practice*, Sue (2006) states, "To persons of color, "whiteness" is most visible when it is denied, evokes puzzlement or negative reactions, or is equated with normalcy" (p. 111). Given that most humans are visual creatures, characteristics that can be seen are the first information utilized to make judgments. Often times, Euro-Americans become blind to their own color and the values and beliefs that are then associated with Euro-Americans, when they deny the color of others. Sue (2003) writes, "Whiteness is transparent precisely because of its everyday occurrence, it represents intuitional normality, white people are taught to think of their lives as morally neutral, average, and ideal" (p. 120). Using a colorblind approach, and making one's color transparent, allows Euro-American counselors-in-training to

avoid the topic of ethnicity because they ignore their own. As Sue indicates, however, it might not be possible to understand the experience of someone else's skin color until one understands their own experience, and acknowledge that some of that experience can be attributed to our own skin color.

The history of the culture and its myths enable us to give meaning to the experiences in our lives. Sue (2004) identified three myths that guide our conceptualization of reality in the United States. These are "the myth of mediocrity (the cream of the crop will rise to the top), the myth of equal opportunity (everyone has a chance to succeed in this society), and the myth of equal treatment (equal treatment is fair treatment)"(p. 766).

There are discrepancies between the typical Euro-American viewpoint that believes discrimination has been greatly reduced or eradicated on the one hand, and the actual experiences of non-Euro-Americans in the United States on the other. Sue (2003) identifies that Euro-American men hold high-level positions far more prevalently than minorities, for example

white men occupy approximately 80% of tenured positions in higher education and 92% of the 400-executives/CEO level positions; they constitute 80% of the house of representatives, 84% of the United States senate, and 99% of athletic team owners. While these statistics are staggeringly compelling, it is compounded by the fact that white men comprise only 33% of the US population (p. 9).

Contemporary statistics of academic achievement, business leadership, parity in political representation, and financial success in the United States do not support a state of racial or gender equality. Rather, these statistics support that there is an uneven playing field for minority populations and women.

Ethnocentric monoculturalism is defined by Sue et al. (1999) as “The invisible veil of a worldview that keeps Euro-Americans from recognizing the ethnocentric basis of their beliefs, values, and assumptions” (p. 1065). This invisible veil blinds Euro- Americans making it so they are unable to identify the value in cultures that differ from their own. Furthermore, Katz (1985) noted “Ethnocentric monoculturalism is manifested in the value of individualism, the protestant work ethic, capitalism, the desirability of certain physical features (blond hair, blue eyes, and fair skin), monotheism (Christianity), monolingualism (English), and a written tradition” (p. 214).

McIntosh (2002) highlights White privilege in terms of Euro-American awareness or non-awareness of his or her own experience of privilege. Whiteness, for some, constitutes a feeling of entitlement and privilege. The very identification that whiteness is normal implies that all other skin colors and ethnicities are abnormal.

Counselor trainees may benefit from discussions that enable them to cognitively process their own cultural experience. Knowing oneself is a process. Counselors-in- training can surpass their current level of cultural awareness by being challenged in their academic settings, to continually quest to know

themselves better today than they did yesterday. Although conversations about prejudice, white privilege and bias may be uncomfortable for some students, it is of the utmost importance that they attempt to understand their cultural lens and how their lens may or may not impact diagnosis of varying cultural populations.

2.2 Counselor-in-Training-Explicit Assumptions & Attitudes

Mental health professionals have been tasked with the ethical responsibility to provide culturally appropriate diagnosis and treatment. In order to achieve this, counselor trainees must know their explicit assumptions and attitudes toward their clients' cultures and their own culture. Aronson, Wilson and Akert (2005) view explicit attitudes/assumptions as those that individuals are aware of and can report on.

The explicit assumptions counselor-in-training experience may increase the likelihood of misdiagnosis and mistreatment with Euro-Americans and Alaska Native populations. According to the 2000 U.S census, there are 98,043 American Indians and Alaska Natives, and 434,534 Caucasians residing in the state of Alaska (U.S. Bureau of Census, 2000). These population sizes further support the need for graduate students, in Alaska, to hone their cultural competencies, as their clients will likely include individuals from each group.

Stereotypes according to Baron, Byrne and Branscombe (2006) are “beliefs about social groups in terms of traits that they are deemed to share” (p. 213). Stereotypical cognitive processes on the counselor-in-training's part can result in inappropriate diagnosis for Euro-American and Alaska Native clients.

Prejudice is “the affective component, or the feelings we have about particular groups” (Baron et al., 2006, p. 213). Kaiser and Pratt-Hyatt (2009) identify that Euro- Americans have an increased likelihood of expressing prejudice when they identify that the minority strongly identify with their minority status, and if the Euro-American has increased identification as a Euro-American. They must be aware of the value and degree to which they identify with being a Euro-American in their personal representation, a strong perception of Euro-American identity increases the likelihood that for some counselors-in-training, social constructs may include prejudice towards those they identify as different, which may lead to culturally incompetent practices.

2.3 Visual and Behavioral Considerations

Counseling students and clients, regardless of cultural differences, are human beings. It is the similar experience of being human that intrinsically ties each of us together. While the similarities are present, it appears that visual differences influence how people *know* and *understand* the *other*. Research done by Lee et al. (2008) studied brain functioning in normal Korean men who underwent Magnetic Resonance Imaging (MRI). During the process, the participants were shown visual pictures of other Koreans (own-race), or Euro-Americans (other race) bearing happy or sad expressions. Results of their research supported that different areas of the brain activated when shown own-race visual pictures versus other-race pictures. These findings offer evidence that differential processing occurs when Korean men are exposed to differences in race and

emotional facial expressions. It seems fair to suggest that counselors-in-training should be aware of the differences they may experience, biologically or experientially, when visually experiencing a Euro-American or Alaska Native individual expressing emotion.

Body language and physical appearance provides counselors with key information about their clients. Shifts in body movement, personal appearance, and language patterns inform mental health providers. The Mental Status Exam (MSE) is an assessment tool that Pomerantz (2008) identifies which enables the counselor to assess the client over the following nine areas: physical appearance (clothing, ethnicity, body type); behavior/psychomotor (agitated, fidgeting); attitude towards counselor (resistant, active participation); affect/mood (congruent mood to topic, flat mood/affect); speech/thought (rate of speech, congruent cognition); perceptual disturbances (hallucinations, delusions); orientation to person, place, and time (present, current location, time of day); memory/intelligence (count back from 100 by seven, remember list of words); and judgment/insight (what would you do if you find a stamped envelope?). Physical appearance and behavioral cues, while they can be visibly seen, do not always translate or convey the same information. Counselors-in-training, who are culturally unaware, may assess their Alaska Native or Euro-American client differently.

Human beings implement, or do not implement, a variety of eye contact behaviors in social situations to convey or enhance their message. Eye contact can

convey a myriad of messages: love, anger, authority, respect, and more. Swaab (2009) finds that when two females have a face-to-face interaction that includes eye contact there is increased understanding and agreement in the negotiation process. Euro-American and Alaska Native peoples, male or female, may implement eye contact behaviors, for a myriad of culture specific rationale, which may differ from other cultures eye contact norms. Counselor trainees would be unethical and culturally incompetent to not take this into account when assessing for meaning of eye contact in the therapeutic process.

In order to provide culturally appropriate diagnosis and treatment, counselors-in- training must educate themselves on cultural norms regarding non-verbal communication. Midgette and Meggert (1991) find that when counselors are unaware of the meaning or importance of their clients' non-verbal communications they increase the likelihood of culturally inappropriate services. Graduate students must strive to understand the non- verbal communication that their cultural clients implement.

Differences exist among cross-cultural populations with regard to the meaning or appropriateness of physical appearance, body movements, and language patterns. Misunderstanding or bias regarding assumptions about personal appearance, behaviors, and language of Euro-American or Alaska Native clients on the part of the trainee may increase the likelihood that culturally incompetent practices, unethical treatment, and misdiagnosis could occur. It is important to reiterate that in order for students and providers to have a full

literature base to support therapeutic endeavors, more research is essential for both Euro-Americans and Alaska Native populations; chapter five identifies a multitude of future research ideas that could be done in these areas.

It appears that it is the experience of difference that may be the catalyst to misunderstanding and misdiagnosis. Counselors-in-training must try to identify how they perceive, conceptualize, and assess Euro-American and Alaska Native clients based on their visual appearance. Euro-American history is fraught with literature that supports the idea that Euro-American culture is superior to other races. An example is found in Kant: “This man was black from head to toe, a clear proof that what he said was stupid” (cited in Ashcroft, 2001, p. 314). These words exemplify the sense that Euro-American race was the causal factor for intelligence, and peoples of different races were less intelligent. Euro-American history is full of documented evidence that non Euro-Americans have been perceived and treated as less than Euro-Americans.

Euro-Americans have a shared history with one another, where language, religion, and cultural values are experienced as the norm. They deem individualism as ideal and development of the self as highly important. However, individualism is not regarded as most important to all cultures (Kirmayer, 2007). Euro-centric-based models support facilitating change at the individual level versus the tribal or community level (Gerstein et al., 2007).

Individualism and collectivism, as cultural norms, influence all cognitive processes and behavioral manifestations. Self-esteem, self-identify, independence,

and all other *I* constructs are representative of Euro-American culture. Cultures that value the *We* versus *I* have different cultural schemas, hence therapeutic efforts must incorporate therapeutic strategies to diagnosis and treat through the clients appropriate *I* or *We* cultural framework (Oyserman & Lee, 2008).

Counselors-in-training must effectively know and understand their culture and the clients culture in order to determine the clients framework of *I* or *We*, and how this cultural framework impacts and influences their cultural wellness.

Sue (2003) discusses racism in his book, *Overcoming our Racism*. He identifies that individuals and communities operate under certain truths. In being an active participant in the Euro-American culture, one is able, should they choose, to assert that their truth is more correct than minority truths. This assertion is supported by the fact that the history of Euro-American culture includes an active process to assimilate or indoctrinate other cultures in order to make them more like the Euro-American culture. Flaskerud (2007) defines assimilation as a situation in which “ the arriving group is absorbed into dominant society and their original culture is overridden by the dominant group” (2007, p. 543). This assimilation process entails blanketed concepts such as god, individuality/collectivism, values, language, perceptions regarding human nature, and historical development (Sue, 2003).

Sue (2003) discusses that in America other societies or groups may be perceived as less developed, uncivilized, primitive, or even pathological. The group’s lifestyles or ways of doing things are considered inferior. Sue notes that

the following physical characteristics such as dark complexion, black hair, and brown eyes; cultural characteristics such as belief in non- Christian religions (e.g., Islam, Confucianism, polytheism.); collectivism, present-time orientation, and the importance of shared wealth; and linguistic characteristics such as bilingualism, non-standard English, speaking with an accent, the use of nonverbal and contextual communications, and reliance on the oral tradition: are usually seen as less desirable by American society (Sue, 2003).

Jones (1997) and Sue (2003) illustrate that the contemporary situation, governing laws, and policies of the United States are based on our country's historic tendencies. These laws have often contained purposeful, intentional, and blatant discriminatory rationales. For instance, there were laws restricting religious and spiritual practices among Native Americans, laws prohibiting Asians from governing their own estates, and a constitutional amendment that counted men with black skin color as only three fifths of a man (Jones, 1997; Sue, 2003).

Livingston et al. (2008) suggest that in order to be a culturally competent counselor, one must have knowledge and respect for cultures, which often differ from their own, as well as knowledge and respect of one's own culture. Furthermore, they assert that counselors should acquire skills that enable them to work effectively with multi-cultural populations. Sue (2004) suggests that difficulties arise in the therapeutic experience, due in part to discrepancies in the Euro-American's perception of the multicultural client's progression and movement towards mental health wellness.

The experience of being a Euro-American is decidedly different from being a person who is non-Euro-American. Similarly to their clients, trainees generally only see and experience the world through their cultural lens. In order to be an effective cultural counselor-in-training, one must consider all that their culture entails. Yamada and Brekke (2008) support that counselors must endeavor to understand wellness and balance through their clients' sociocultural lens.

In order to move toward being a culturally competent counselor, one must realize that the experience of being Euro-American includes benefits and the power to create and execute reality based on truth and knowledge created by Euro-Americans for Euro-Americans. After a counselor-in-training effectively understands the Euro-American status of privilege, they can begin to understand how this belief system impacts attitudes, perceptions, and presuppositions held possibly by both the client and the counselor trainee. Ultimately, this may result in the realization that our current systems of labeling human behaviors may be deficient in scope and applicability to multicultural populations.

While similarities exist within all cultures, it is the nuances of difference that may result in an altered understanding of reality and wellness. Pedersen (1995) discusses that mental health professionals must be cautious to not overemphasize similarities or differences that persist across cultures as this approach can increase the likelihood that stereotyping will occur. The most poignant of similarities is that all cultures have sought over time to understand their existence. According to Kambon (1998), for some cultures this has led to the

spiritual quest of knowing a higher power, and at times, examples of the religious quest of knowing God.

Maslow's (1948) hierarchy of needs represents a model that organizes needs according to basic needs, safety and security, love and belonging, esteem, identity, and self-actualization. While this method for understanding how human needs are organized, there are other, more indigenously aligned methods for dividing our needs.

Cross (2003), for instance, identifies a relational worldview theory in which four quadrants--mind, body, spirit, and context--must be considered in order to be culturally aware. The mind quadrant can derive balance by being attuned to cultural literature, stories, and dreams. The body quadrant can achieve balance by adhering to cultural attuned diets, remedies, rituals, rest, and physical activities. The spiritual quadrant achieves balance by participation in culturally appropriate ceremonies, rituals, or prayer, to name a few. The context quadrant may implement healers, social supports, and family in order to manifest balance. This theory further holds that the human experience is meant to result in balance. Balance is dependent on each of these quadrants being fulfilled in a culturally appropriate manner. Implementation of this method may be beneficial for counselors-in-training to consider as it may assist in facilitating their client's cultural wellness.

For counselors-in-training who serve Alaska Native clients, it is important they have working knowledge of the Alaska Native culture historically, as well as

currently. As a mental health professional, one must understand the Alaska Native traditional cultural practices such as language, ceremonies, family structure, social, religious and spiritual practices, as well as health practices, including diet, in order to assist the Alaska Native client in their wellness (Norton & Manson, 1996). It is equally important to understand, through the client, the perceived impact of cultural loss and current state of cultural self. Specific attention must be paid by the counselors-in-training to *know* and *understand* how the client or clients including individuals, families, couples, groups, and communities experience their Alaska Native culture.

2.4 Alaska Native Culture

In order to be a culturally competent counselor, one must be aware of the history of Alaska Native clients. Along with being aware of the Alaska Native client's history, counselors-in-training must aim to understand how that history, or to what degree that history, is influencing their client's current state of wellness. According to Norton and Manson (1996), Alaska Native's history includes loss of "ancestral lands; restriction of traditional means of obtaining food, shelter, and clothing; imposition of alien forms of governance; mandated education in White schools; and the destruction of language and religion" (1996, p. 856). Counselors-in-training must be cognizant that the history they themselves derive from may have differences that may influence their understanding of the Alaska Native client's history. Certainly, a history where one's culture is altered in a forceful manner may lead to differing perceptions of Euro-American culture, as well as

their own Alaska Native cultural wellness. Aponte and Barnes (1995) note that acculturation

can be viewed as either unidirectional process in which a person relinquishes his or her ethnic characteristics or a bidirectional process in which the ethnic person assumes some of the characteristics of the second culture, retains his or her ethnic culture and identity, and influences or changes the second culture. (p. 27)

Cultural competence does not mean placing wide sweeping generalizations about specific cultures to all peoples who identify as that culture, or in a word, stereotyping. Rather, it means *knowing* and *understanding* through your client's cultural lens. Research done by Hensel, Haakedson, and Mohatt (2003) supported that all Alaska Natives who were participants in their study identified spiritual beliefs, religion, and religious training as important in their lives, and influencing factors in their decisions regarding sobriety.

Mental health providers must take heed of this research, in order to provide culturally competent counseling to Alaska Native clients. Counselors must include an exploration of identified wellness and inclusion of identified religious and spiritual practices when the Alaska Native client presents with substance or alcohol concerns. If the counselor does not include discussion of religious or spiritual components that influence substance and alcohol use, they would be ignoring a value that Alaska Natives view as impacting or influencing their

wellness.

It is important to note that for some Alaska Native clients there may be gender- specific labor, skills, and goals that must be achieved in order to fulfill their cultural self. For example, research done by Lisa Frink (2009) identified that the killing of a bearded seal for a Yup'ik boy represents his transformation into adulthood. Additionally, this researcher supported that male and female Alaska Natives may have specific gender labor divisions. Eskimo women who have mastered the traditional lifestyle to include subsistence and are independent are often times referred to as *elder* (Frink, 2009). Euro- American boys do not achieve manhood by killing a seal, and the majority of Euro- American women do not include subsistence lifestyle in their repertoire, hence, this is an area that counselors-in-training must be aware of when facilitating therapy with Alaska Natives.

Counselor trainees working with Alaska Native clients will need to explore how Euro-American contact, and the experience of acculturation, have impacted their Alaska Native clients cultural values and practices. Providers may find that Yup'ik clients, versus other Alaska Native peoples, for example, experience contact and acculturation at a different rate. This is due, in part, to Euro-Americans rejecting the geographic location of the Yup'ik land upon arrival, hence altering the timeline of contact for the Yup'ik peoples (Wolsko et al., 2006).

Wolsko et al., (2006) report Yup'ik people identify that wellness was intrinsically woven into traditional Yup'ik lifestyle; this includes subsistence lifestyles, native foods, traditional medicines, balance in personal relationships, and respect and reciprocity. Counselors-in-training must be aware of the Yup'ik cultural value system and how wellness occurs within it.

Subsistence lifestyles, such as hunting and fishing, are quite different than Euro- American lifestyles. While each of these cultures implements nutrition behaviors to maintain the biological system, the behaviors to obtain food and types of nutrition consumed are culture based. For example, research done by Ellis Ransom (1946) identified Aleut natural foods: halibut, salmon (of many varieties), mussels, seal meat, beans, lettuce, carrots, grass brewed into tea, wild berries, eggs, and native roots, to name a few.

Counselor trainees need to be aware that if the client and the counselor identify that they are different, the more communication and monitoring of the client's internal dialogue becomes difficult for the counselor (Irvin and Pedersen, 1995). This is important, as trainees, need to be cognizant of this so that they are able to implement strategies that will assist them in effectively facilitating therapeutic endeavors with clients who differ from themselves.

2.5 Language

In mental health efforts effective communication is essential in attempts to facilitate a client's movement towards wellness. Bhatt (2001) identified that the English language is utilized across the world; currently, 44 countries identify

English to be the “official status” of their language (p. 153). The English language represents to the Euro-American their mother tongue, the language they have always known, and the language they verbalize and cognitively process automatically.

Language occurs when an individual audibly constructs a sound that another is able to put meaning to, in this case, English. Structuralist linguists and linguistic anthropologists continue their quest to understand the language and the meaning derived from culture, the *I*, pronoun changes, language contact, and dialects, to list a few (Johnston, 2000). For counselors, linguistics has been essential in identifying the variables a mental health provider should consider in understanding language with all clients.

What seems to be the most important feature about language is that language exists. The existence of language supports that there is an exceeding desire to socialize with others, so much so that it outweighs the difficulties one may experience in the attempts to do so. For some counselors-in-training, utilization of the English language may be their cultural norm. The Euro-American counselor has an entire history of English speaking heritage. While most, if not all, mental health providers would identify that effective communication must occur in the therapeutic relationship, many fail to discuss or identify the meaning or value judgments that, trainees, may explicitly experience when they hear language patterns differing from their own tongue.

Upon contact with Euro-Americans, Alaska Natives were forced to adopt English as their language. The educational and religious systems were dominantly utilized in order to indoctrinate Alaska Natives, both children and adults, towards English linguistic competence (Charles, 2005). By forcing Alaska Natives to abandon their mother tongue and adopt English as their first language, it seems fair to suggest Alaska Natives may have perceptions of the English language, which may differ from that of the Euro- Americans.

Alaska Natives have traditional languages that are not English language based. Ashcroft (2001) identifies how cultural norms of word choice, tone, pause, dialect, and delivery of language patterns impact what is meant to be conveyed, or not, in each communication experience. Language is implemented to inform, as well as to conceal (Ashcroft). Charles (2005) identifies that 50 percent of the 20,000 Yup'ik Eskimos speak their traditional language fluently. Counselors-in-training must be aware of the efforts made by the Yup'ik people to pass on and document their traditional language. A comprehensive dictionary entitled *Yup'ik Eskimo Dictionary* was created to document Yup'ik language (Charles). Graduate students providing services to Yup'ik clients should certainly be aware of the efforts that the Yup'ik peoples have set forth to maintain their traditional language.

Manson (2000) identifies that some Alaska Native cultures do not have the words depression or anxious in their language. While the words depression and anxious are not present in the language of some Alaska Natives, it does not equate

to an absence of the experience of depression or anxiousness (Manson). It seems fair to suggest that if one of the Alaska Native normative cultural language patterns is misunderstood or differs from that of the counselor-in-training, it may increase the likelihood that diagnosis can be impacted by language differences, if the trainee is unaware.

Language includes not only the explicit verbalizations and language patterns, but also the cultural meaning linked implicitly to the verbalizations and language patterns utilized. Counselors-in-training must diligently strive to achieve cultural competency in understanding and knowing the explicit meanings of language patterns for their Euro- American and Alaska Native clients.

Students must pay special attention to understand the meaning the Alaska Native client intends when utilizing language, to convey their cognitive processes. The counselors-in-training must learn and understand their Alaska Native clients' meanings and respond in a similar enough language that the client is understood.

2.6 Social Support

Euro-Americans commonly seek out others to assist when they perceive stressors are occurring and impacting them negatively (Kim, Sherman, & Taylor, 2008). Psychotherapy supports the Euro-American cultural norm of utilizing mental health services as a form of social support. Not all cultures implement social support strategies from a mental health provider as their norm. The trainees must be cognizant of their personal comfort related to obtaining and giving social support and how this may differ or vary for other cultural populations, including

Alaska Natives.

An important piece for the Euro-American counselor-in-training is to *know* and *understand* how the Euro-American experience and cultural norm of requesting assistance and mental health treatment may be cognitively constructed similarly and differently than their Alaska Native clients. Some Alaska Native clients may deem it culturally appropriate to consult elders, while others may not identify the elder to be essential in their personal wellness. Incayawar, Wintrob, Bouchard, and Bartocci (2009) identified that the body of literature is seriously lacking related to Alaska Native elders use or role in the healing experience. Euro-American mental health providers who provide services to Alaska Natives must gain knowledge from the Alaska Native client in order to determine the role of the elder in their healing experience.

Counselors-in-training must diligently explore what social support wellness looks like for Alaska Native clients. Trainees must also aim to understand the Alaska Native client's perspective on the Euro-American based therapeutic experience. Additionally, graduate students must aim to implement culturally appropriate therapeutic methods in order to facilitate the Alaska Native client's desired culturally appropriate social support. For some Alaska Native clients, this may best occur outside of the Euro-American counseling context, to potentially include elders and other peoples deemed important in their wellness process.

Counselor trainees must explore each Alaska Native clients personal experience within his or her Alaska Native culture. Trainees may benefit from

exploring if and how their personal history may influence or impede the way in which the graduate student conceptualizes, and knows, the Alaska Native client's cultural-self. Cultural competence includes knowledge of the client's cultural self, in this research a Euro-American and an Alaska Native. Students, who are aware of these similarities and differences in cultures, may be more apt to explore how these impact the therapeutic process, as well as their diagnosis, assessment, and treatment choices for their cultural clientele.

In conclusion, counselors-in-training must, according to APA and ACA, be aware of their own cultural self; deep reflection and assessment of self in many categorical areas should have effectively occurred. Secondly, trainees must *know* and *understand* the Euro- American and Alaska Native client's cultural experience. Concurrently, the students must accurately assess the impact or influence of ethnic differences for the Euro-American and Alaska Native client. For counselors-in-training, this may include effective awareness of the explicit attitudes that they experience with Euro-American or Alaska Native clients. Trainees may attempt to understand the explicit attitudes the client experiences towards the counselor. Once trainees are culturally competent in these areas, they can apply that knowledge to determine appropriate Euro-American and Alaska Native assessment tools, diagnosis, and treatment practices.

2.7 Diagnosis and Treatment

People in the United States are experiencing daily stressors that are compounded by difficulties due to the economy, illness, and military efforts, to

name but a few examples. A large number of individuals and families will be unable to obtain mental health treatment due to financial constraints and a lack of health care insurance (Gone & Alcantara, 2007). Zuckerman, Haley, Roubideaux, and Lillie-Blanton (2004) identified that Alaska Natives experience higher instances of being uninsured, and experience higher degrees of difficulty in accessing health care. While the federal government has made attempts to fund health services for members of tribes, the financial resources are inadequate to meet the needs of all Alaska Native tribal members (Zuckerman et al.).

Some Alaska Natives do not have their essential health care needs met by the federal government. Those that meet income-level requirements can apply for alternate insurance options, such as Medicaid or Tri-Care insurances. Those who qualify must adhere to the guidelines identified in service agreements, which outline treatment services within their insurance plan. For some, this translates to a situation in which only Euro- American-based therapeutic services are covered by insurance, and then only minimally. Because insurance companies pay for services from counselors trained and licensed according to Euro-American standards, and these counselors tend to reside in larger cities in Alaska, rural Alaskans often have to travel great distances to access services they need. Likewise, federally funded health corporations locate most of their counseling and mental health facilities in a limited number of communities.

Within the existing framework of mental health services, the Diagnostic Statistical Manual-IV-TR (2000) represents the authority on determining

diagnosis for both treatment and service payment (APA, 2000). The DSM-IV-TR (2000) dedicates the last 7 out of its 904-page text, to culture, these 7 pages are arguably some of the most important. Providers and clients certainly benefit from the inclusion of the cultural formulation when utilized effectively. The DSM-IV-TR additionally identifies 26 culture-bound syndromes of which providers should be aware. An example of a culture-bound syndrome is Dhat. Dhat is a diagnosis predominantly identified with cultural groups from India, Sri Lanka and China, in which symptoms include the experience of anxiety and severe concerns about illness, which are linked for the client when semen is discharged from the body, urine changes to a white color, and one becomes tired and excessively weak (APA, 2000). It seems fair to suggest that Euro-American culture often links different values and experiences to times in which semen discharge occurs, accidentally or otherwise.

Dana (1998) asserts that the DSM-IV-TR (2000) does not include enough information for providers to diagnosis, assess, and treat multi cultural populations. Feisthamel and Schwartz (2009) identify that minimal research has been conducted regarding impact of race on diagnosis in the DSM-IV-TR (2000) and how race impacts onset, symptoms, course, diagnosis, and treatment. It has made additions that reflect recognition that culture must be considered. In addition, it identifies the following areas in the seven-page section on culture: subsections that specifically address culture, gender, and age; a cultural formulation outline, and a list of culture bound syndromes.

Mental health providers must also take heed when assessing the emotionality of clients from other cultures. Manson (2000) identifies that cultural groups differ in the language and estimations of the degree of severity, importance of, significance of, and meaning correlated to emotion. This is exemplified by the difference in meaning that Euro-Americans and Hopi peoples have for constructs such as guilt, sinfulness, and shame (Manson, 2000). Incongruence in understanding the Hopi client's language and emotional experience can result in lessened accuracy in assessing symptomology, resulting in misdiagnosis and culturally incompetent treatment.

Aisenberg (2008) identifies that evidence-based practices (EBP), while supported by empirical research, do not effectively include many cultural populations as research participants. Miranda, Bernal, Lau, Kohn, Hwang and LaFromboise (2005), however, support differing viewpoints. They identify the body of literature available does support EBP for some ethnic minority populations. In order to be culturally competent, counselors-in-training must know the populations that EBP is useful for, and those they may not serve best. Hays (2009) identified a ten-step process for counselors to implement in order to effectively utilize Cognitive Behavioral Therapy (CBT) with cross-cultural populations. Appendix Q identifies the ten steps Hays identifies.

Researchers Simmons, Novins and Allen (2000) collaborated with American Indian and Alaska Natives in order for them to express their words and definitions of children with Severe Emotional Disturbance (SED). The SED

definition set forth by the Fairbanks Native Association (FNA) and Tanana Chiefs Conference (TCC) was reported to be

a temporary disharmony involving the community, school, and family that affects the physical, emotional, spiritual and intellectual well being of its members. The healing of our children, families, and communities is a flexible, evolving process that returns us to our most basic belief that children are precious (Ch'eghutsen) (p.7)

Certainly, counselors-in-training should acknowledge this definition, the utilization of this framework may assist in culturally competent practices.

Currently, the literature base for Alaska Natives is insufficient to determine the specific rates of misdiagnosis, over diagnosis, or under diagnosis for Alaska Native clients. Research done by Begger, Bouk, Boussaid, Terwogt, and Koot (2009) identifies that Euro-American counselors have an increased likelihood to under diagnosis autistic children who were ethnic minorities. This research supports the possibility that Euro-American counselors may diagnosis an Alaska Native client differently than a client who is Euro-American.

Assessment tools are commonly utilized in mental health practice, and most are constructed and implemented through Euro-American cultural constructs. Most assessment tools are delivered in either written or spoken English. The less proficient an individual is with the English language, the less likely the assessment tool will yield beneficial results (Solano-Flores, 2006). A

comprehensive review of the literature over the past decade via Academic Search Premier and Anthrosource identifies there are no assessment tools created for Alaska Native people(s). While it is clear that culturally appropriate assessment tools are needed for Alaska Native peoples, this area of research remains an area in need as it pertains to Alaska Native ethnic cultures specifically.

Sternberg (2004) writes that culture influences what components are most important in determining intelligence. This is exemplified by the identification that intelligence is achieved when the individual displays benevolence and doing what is deemed *right*, within the Confucian perspective. Taoists identify that what leads to intelligence is knowledge of oneself and others, high levels of humility, no judgment on self and others, as well as achieving balance with the external world. Euro-Americans identify enjoying and engaging in educational and situational experiences facilitating the learning experience (Sternberg).

Barnhardt and Kawagley (2005) note that the American Association for the Advancement of Science (AAAS) handbook identifies indigenous traditional knowledge to be

Information that people in a given community, based on experience and adaptation to a local culture and environment, has developed over time, and continue to develop. The knowledge is used to sustain the community and its culture to maintain the genetic resources necessary for the continued survival of the community (p. 12).

Alaska Native clients may have their own definition of intelligence, or what traditional knowledge entails, and trainees must strive to understand this through the Alaska Native cultural lens.

Interestingly, research done by Sternberg (2004) illustrates that there were differences in what it meant to be intelligent for Latinos and Asians residing in San Jose, California. It seems that ethnic differences must be taken into account when counselors- in-training attempt to assess intelligence, as the Euro-American intelligence construct may not reflect the same content or processes that Alaska Native clients identify intelligence to be.

Gender is another cultural variable that can influence diagnosis. Research conducted by Hobara (2005) expressed gender value differences in Japanese and Euro- Americans. Both Japanese and Euro-American males identify that it is more socially acceptable for females to verbalize and express pain than their male counterparts. This study also supported that males are less supportive of other males when they verbalize the experience of pain. Males utilized more supportive tactics for females when the male identified the female had experienced pain (Hobara). Counselors-in-training need to be aware of how their gender, male or female, influences their understanding of presenting symptomology, including pain.

Each individual, regardless of his or her identified culture or gender, has a personality. Some training programs may educate their students to utilize objective tests, such as the Minnesota Multiphasic Personality Inventory (MMPI),

or the Neuroticism Extraversion Openness Personality Inventory (NEO-PI-R), to assess the personality of their clients (Groth-Marnat, 2003). Counselors-in-training must be made aware that most assessment tools have been created by and are implemented through the Euro-American cultural construct of personality.

It is fascinating to note that Carson, Butcher, and Mineka (2000) identify the Inuit of Alaska and the Yoruba of Nigeria's definitions of psychopathy. The Inuit definition of psychopathy is that the "mind knows what to do, but he does not do it...This is an abstract term for the breaking of the many rules when awareness of the rules is not in question," while the Yoruba definition is "a person who always goes his own way regardless of others, who is uncooperative, full of malice, and bullheaded" (Carson et al. 2000). Graduate students must be cognizant of the different definitions set forth by their cultural clients, as it is these definitions of personality constructs that guide counselors-in-training in culturally competent practices.

Counselor trainees can benefit from the research conducted by Hobarra (2005) that illustrates how Euro-Americans receive higher levels of pain medication post operation and when experiencing back pain. Additionally, Euro-Americans report increased disruption in their social, sexual, emotional, behavioral, physical, and career paths when experiencing pain versus other cross-cultural populations (Hobara). Interestingly, the Euro-American experience of pain may influence the counselor's diagnosis and treatment by either overemphasizing or underemphasizing the symptom of pain.

A review of the literature available for Alaska Native populations identifies that the topic of substances and alcohol are discussed far more than other areas. How does this body of research impact the counselors-in-training assessment of Alaska Native clients? Does it result in over or under diagnosis of substance related disorders? Do Alaska Native clients who choose the path of sobriety suffer at the hand of prejudice and stereotype based on Euro-American perceptions of their culture? Counselors-in-training, who possess personal schemas that include stereotypes or prejudices, may result in serving Alaska Native populations in unethical and culturally incompetent manners.

In summary, students providing services to Euro-American and Alaska Native clients must consider how their cultural self, educational knowledge, cultural history, training, and applied practices inform them in their diagnostic impressions of these populations, who may differ in culture from themselves.

Chapter Three

Methods

In order to be effective counselors in multicultural towns and schools, students in graduate counseling programs need education, practice, and evaluation (both by themselves and their supervising professors) regarding skills related to cross-cultural diagnosis. As previously discussed, the results of recent studies on the effects of gender, race, and ethnicity show that historically Euro-American men are perceived more positively than non-Euro-Americans. Some of these studies indicate that this difference in perception persists in educated, culturally sensitive people. Even those who have been consistently exposed to other ethnicities, and even those of non-Euro-American ethnicities, continue to perceive Euro-Americans more favorably than others. Counselors- in-training may not be immune from this tendency in perception.

3.1 Research Questions

The main research question the present study examines: given the identical client information, history, and presenting issues, but with variation in ethnicity, did the tendency to view an Alaska Native male less favorably than a Euro-American male persist in counselors-in-training? If so, how did this difference manifest itself?

The quantitative hypothesis was that, all else being equal, counseling students would, view an Alaska Native client more negatively than a Euro-American client. They would express this tendency through more frequent

diagnosis, more extreme diagnoses, or lower GAF scores. The quantitative null hypothesis was, therefore, that there would be no difference in the frequency of diagnosis, intensity of diagnosis, or GAF score given to otherwise identical Alaska Native and Euro-American client.

3.2 Participants

Participants were recruited who were currently enrolled in the MEd Counseling Master's degree program housed at the University of Alaska Fairbanks; the Counselor Education Master of Education at the University of Alaska Anchorage,; and the Master of Science in Counseling Psychology, at the Alaska Pacific University who have completed between 50-350 face-to-face counseling hours including individual counseling, group counseling, couples counseling, and individual and group supervision hours, but have yet to graduate. In order to include distance students enrolled in the counseling masters programs, the current study was delivered online via Google Apps spreadsheet and Web site. This delivery method enabled all participants enrolled in the counseling masters degree programs to have equal opportunity to participate in the present study. It is important to note that Google Apps is a secure site ensuring confidentiality. While this research identifies a multitude of concepts that can benefit counselors, this research is more specifically useful to graduate students training to become counselors. This is the target population, who will, upon graduation, regularly conduct mental health practices with Euro-American and Alaska Native clients.

Criterion sampling was used to select participants for this research.

Participants had equal opportunity to participate in this research if they meet the following criteria: (1) currently enrolled in the counseling masters degree program housed at the University of Alaska Fairbanks, the University of Alaska Anchorage, or Alaska Pacific University; (2) have completed at least one semester of on-campus practicum experience; (3) have accrued 50-350 client hours; (4) but have yet to graduate.

3.3 Procedures

Once the committee approved the dissertation proposal, it was submitted to and approved by the UAF Institutional Review Board (IRB) application (see Appendix A). Next, a male Alaska Native and male Euro-American actor were recruited to act in the roles of client, for the 30-minute scripted mental health intake session video. Both actors were provided the mental health script (see Appendix E) in advance of recording the intake session. Actors were trained to read the text exactly as written. To ensure that actors read text identically, the script was on a computer screen, behind the counselor during the intake session. This method enabled the actors to read the text, without the text being apparent in the camera shot. In order to reduce extraneous stimuli, the counselor was not in the camera shot. In order to minimize differences in perception, male actors were instructed to wear a dark t- shirt and casual pants. Participants heard a female counselor's voice asking the intake questions, during the mock mental health video sessions. Since the female counselor was not in camera shot, she read the

intake questions by utilizing a hard copy format of the mental health script. By ensuring that the female counselor, the male Alaska Native client, and the male Euro-American client spoke the exact same words during the mock mental health sessions, the potential influence of non-essential differences were reduced.

All students who (a) self identified as a graduate student in either the Counseling Masters degree program housed at the University of Alaska Fairbanks, the Counselor Education Master of Education, at the University of Anchorage Alaska or the Master of Science in Counseling Psychology, at the Alaska Pacific University, (b) report one-semester of practicum experience, (c) and agreed to participate, were included in this study. During the fall semester of 2010, participants were recruited via emails to instructors teaching courses to graduate students housed in the counseling graduate program (see Appendix B). Participants were also recruited via email and announcement postings on counseling program list serves (see Appendix C). Finally, students were recruited via in-class announcements.

Participants were provided a participant information sheet (see Appendix D). The participant information sheet provided a description of the current study; it explained to participants that the benefits of this research are identified as an increase in general scientific knowledge, while risks of participating may include time expenditure and potential discomfort. The voluntary nature of the study was explained to the participants, and it was explained that there was no penalty for choosing not to participate. Finally, contact information was provided, should

participants have questions.

Participants who chose to volunteer were asked to complete a brief demographic survey. The demographic survey requested participants to identify their gender and age. Participants were informed that they could choose not to answer any demographic questions that bothered them. Participants then watched a scripted, 30- minute video recorded mental health intake session, with an actor portraying a client coming for service at a local clinic. Participants watched a video in which the client was either a male Alaska Native or male Euro-American client. Participants were randomly assigned to view either the Alaska Native client or Euro-American client.

Participants, upon completion of the video, were prompted to complete an intake form, and multi-axial diagnosis of the client (see Appendix E). The intake form asks participants to identify the client's name, date of birth and gender. Next, participants were prompted to provide their impressions of the client via the writing of a Mental Status Exam (MSE). After this, participants wrote their impressions of the client's presenting concerns, history of mental health treatment, personal history, family history, and physical health. Finally, participants were prompted to provide a multi-axial diagnosis and GAF score for the client.

3.4 Analysis

Completed intake forms were compared and evaluated through both quantitative and qualitative methods. Descriptive statistics were used to describe

the sample's gender and age in percentile. The quantitative hypothesis was that, all else being equal, counseling students would view an Alaska Native male client as more maladaptive than a Euro-American male client. They would express this tendency through more frequent diagnosis, more extreme diagnoses, or lower GAF scores. The quantitative null hypothesis was, therefore, that there would be no difference in the frequency of diagnosis, intensity of diagnosis, or GAF score given to otherwise identical Alaska Native male and Euro-American male client.

Qualitatively, Strauss and Corbin's (1990) three step analytic process, grounded theory was used to analyze the descriptive part of the intake form. The participants written responses to client's name, date of birth, gender, MSE, presenting concerns, history of mental health treatment, personal history, family history, and physical health represent the data sets to which grounded theory was applied. The first step in the grounded theory approach was to open code the data, therefore categorizing and naming phenomena. Each written response was analyzed in discrete parts: entire response, paragraph, sentence, and word frequency. By analyzing data in discrete parts it ensured that similarities and differences referenced in data was discovered, such as relative difference on emphasis of particular issues or experiences. Additionally, a software program was utilized to determine average number of words utilized to describe the client, in each of the above areas.

The second step was to Axial code the open coded data. Axial coding allowed the connections between categories to emerge. It is at this stage when

condition specific phenomena and non-condition specific phenomena was identified. In this process, the relationships within the data emerged. The final step was selective coding. At this stage, the first goal is to identify one main category. Next, all other related categories were linked to the main category. While this step is similar to step two, it was done at a higher level of analysis in order to form the model of this phenomena (Strauss & Corbin, 1990).

Axis I through IV, of the multi axes diagnosing systems set forth in the DSM-IV-TR (2000) were analyzed by developing percentages of types of diagnosis that the Euro-American and Alaska Native client were given. A two-tailed t-test, for the two independent samples, was done utilizing Excel to determine the difference in means of GAF scores, Axis V, between the counselors who viewed the Euro-American male client and the counselors who viewed the Alaska Native male client.

In summary, this research is a mixed methodology approach to answer the research question: given identical client information, history, and presenting issues, but with a variation in ethnicity, did the tendency to view an Alaska Native male as less adaptive than a Euro-American male exist in counseling students who are enrolled in a counseling masters degree program housed at either the University of Alaska Fairbanks, University of Anchorage Alaska, or Alaska Pacific University? If so, how did this difference manifest itself?

Chapter Four

Results

The main research question the present study explores is when presented with identical client information, history, and presenting issues, but with a variation in ethnicity, does the tendency to view an Alaska Native male as less adaptive than a Euro-American male exist in counseling students enrolled at either the University of Alaska Fairbanks, the University of Alaska Anchorage, or Alaska Pacific University? If so, how does this difference manifest itself?

This chapter is split into three sections in an attempt to convey the results in sequential style, thus enabling the reader to understand the qualitative and quantitative results of participant responses in this research. The first section identifies the descriptive statistics of the participants gender and age who volunteered to participate in this research. The second section discusses the qualitative results of the participants written responses. The participants written responses were assessed in the following areas of the client's intake form: name, D.O.B., gender, mental status exam, presenting concerns, history of mental health treatment, personal history, family history, and physical health. Strauss and Corbins (1990) three step analytic process, grounded theory, was used to analyze the descriptive part of the intake form. The final section of this chapter concludes with percentages of diagnosis, diagnosis extremities, and the results of a two-tailed t-test, which identifies if a difference in GAF score means exist between the

counselors in training, who viewed the Euro-American male client and the counselors who viewed the Alaska Native male client.

The population the current study describes are those students who chose to participate and were enrolled, at the time of data collection, in either the MeD in Counseling program housed at the University of Alaska Fairbanks; the Counselor Education Master of Education, at the University of Alaska Anchorage; or the Master of Science in Counseling Psychology, at the Alaska Pacific University. Additionally, participants had completed at least 50-350 face-to-face clinical hours including individual counseling, group counseling, couples counseling, individual and group supervision hours, and had yet to graduate.

4.1 Descriptive statistics

The sample size for the present study is $n=12$. The observed sample was comprised of six male participants and six female participants. Of the 12 (total) participants, five participants, four males and one female, viewed the Euro-American client's mock mental health intake session video. Of the remaining seven participants, five females and two males, viewed the Alaska Native's mental health intake session. Table 1 visually displays the distribution of participants.

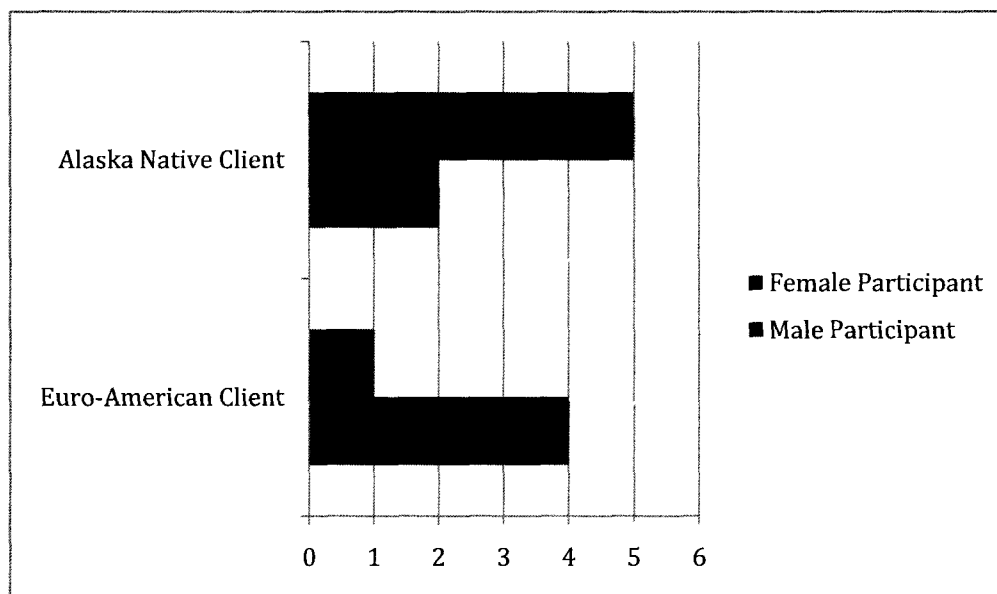


Figure 1. Participant Distribution

4.2 Participants Age & Gender

Participants, male and female, ranged in age from 22-59, with a mean age of 34. The age range of female participants is 22-59. The mean of female participants age is 36.3. The age of the female, who viewed the male, Euro-American client is 31. The mean age of the females who viewed the male, Alaska Native client is 37.4. The mean age of the male participants is 27.71. The mean age of the male participants who viewed the Euro-American client's intake session, is 34.25. The mean age of male participants who viewed the Alaska native client's intake session, is 28.5. Table 2 visually displays the participants mean ages.

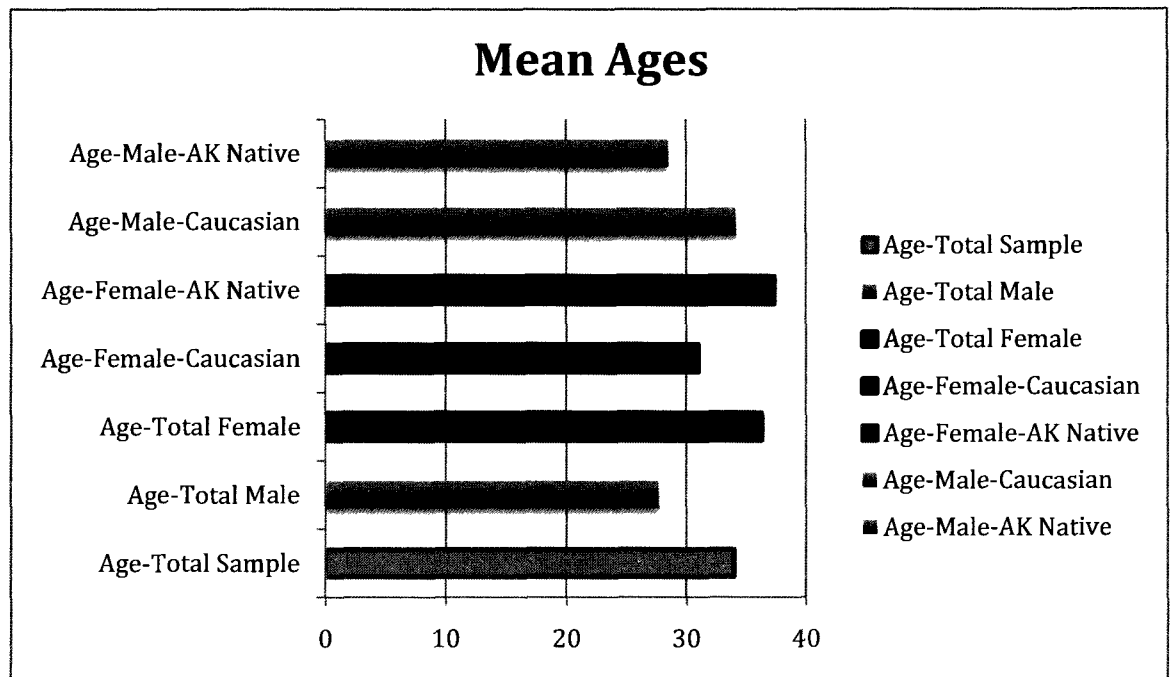


Figure 2. Participants Mean Age

4.3 Qualitative Results

Qualitatively, Strauss and Corbin's (1990) three step analytic process, grounded theory, as previously described, was used to analyze the descriptive part of the mental health intake form. The following items on the mental health intake form represent the items that grounded theory was utilized in analyzing: client; name, date of birth, gender, MSE, presenting concern, history with mental health treatment, personal history, family history, and physical health. In order to be identified as a theme, three units of analysis, or more, had to be coded to equal a theme.

4.4 Client Name

The first item on the intake form asked participants to identify the client's name. Participants who viewed the Euro-American client's mock mental health intake session video identified the most frequent theme to be Jerry Caruk (4), the client's full name.

Participants who viewed the Alaska Native client, mock mental health intake session video, identified the most frequent theme to be Jerry Caruk (4), the clients full name. The second most identified theme is "don't recall" or Jerry (3). Table three visually describes these results.

Euro-American Client-Name	Frequency	Alaska Native Client- Name	Frequency
Jerry Caruk	4	Jerry Caruk	4
Jerry	1	Dón't recall or Jerry	3

Table 1. Client Name

4.5 Client Date of Birth

Participants who viewed the Euro-American client's mock intake video identified the most frequent, and only, theme to be, 1991 (5). No participants were unable to recall any information related to the Euro-American clients date of birth.

Participants who viewed the Alaska Native client's mock intake session identified the most frequent theme to be the number 19 (4). The second most frequently identified theme is "no age identified" (3). Examples of submissions that were included in the theme "no age identified" are "Don't Recall" or 00/00/0000. Table 2 illustrates the responses for the Euro-American and the Alaska Native client's date of birth.

Euro-American Client- D.O.B.	Frequency	Alaska Native Client- D.O.B.	Frequency
Themes		Themes	
1991	5	Correct Age (19)	4
		No response	3

Table 2. Date of Birth

4.6 Client Gender

During the mock intake session, the counselor asked Mr. Caruk if he was a Male or Female. Mr. Caruk replied, "I am a male." The client's gender was discussed one time during the session. Of the participants who viewed the Euro-American client, the most frequently identified, and only, theme is, male (5). Participants who viewed the Alaska Native client identified male (7) as the most frequent, and only, theme. Table 3 illustrates the responses for the Euro-American and the Alaska Native client's gender.

Euro-American Client- Gender	Frequency	Alaska Native Client- Gender	Frequency
Themes		Themes	
Male	5	Male	7

Table 3. Client Gender

4.7 Mental Status Exam

These results identify the themes, in descending order, and are subcategorized with maladaptive, adaptive, or neutral definers. Maladaptive themes identify that the client is not functioning optimally in this area. An example of a maladaptive theme is a maladaptive mood. Adaptive themes identify the client is functioning effectively in this specific area. An example of an adaptive theme is adaptive cognitive capabilities. Neutral themes neither identify a functioning or nonfunctioning component.

Participants identified adaptive cognitive capabilities (10) as the most frequently identified theme for the Euro-American client. Submissions that supported the theme adaptive cognitive capabilities are: memory good or able to remember 3 words. The second most identified theme is adaptive normal/healthy (4). Submissions that supported the theme of adaptive healthy/normal are submissions such as “normal” or “competent.” The Euro-American client had two themes for the MSE section of the intake form.

The most frequently identified theme for the Alaska Native client is adaptive cognitive capabilities (23). An example of a submission that supports the

theme adaptive cognitive capabilities is that “his memory, attention, and concentration are good.” The second most frequently identified theme is maladaptive language/behaviors (9). Examples of submissions that support the theme of maladaptive language/behaviors are that “since he was very quiet it seemed that he might be going through a tough time,” or “Jerry’s speech is somewhat slow.” The third theme is maladaptive mood (7). Maladaptive mood is exemplified by “looked very sad from time to time,” or had a “depressed mood.” The fourth most identified theme for the Alaska Native client is maladaptive substance use (6). Maladaptive substance use is exemplified by “taking sleeping pills” or consuming “6 alcoholic beverages a week.” Neutral clothing is the fifth most frequently identified theme, two participants identified adaptive clothing while the other two identified maladaptive clothing, resulting in a neutral clothing theme. An example of maladaptive clothing is that “the client was dressed in a black shirt, which may imply he is not feeling very good about himself.” An example of a submission that supported adaptive clothing is that he was “dressed appropriately.” Maladaptive thoughts (3) represent the sixth most frequently identified theme for the Alaska Native client. An example of a maladaptive thought is “irrational beliefs.” The seventh theme identified for the Alaska Native client is adaptive active participation (3). An example of adaptive participation is that he was “engaged and willing to answer questions”. Table 4 illustrates the responses for the Euro-American and the Alaska Native client’s mental status exam.

Euro-American Client- MSE	Frequency	Alaska Native Client- MSE	Frequency
Themes		Themes	
Adaptive Cognitive Capabilities	10	Adaptive Cognitive Capabilities	23
Adaptive Normal/Healthy	4	Maladaptive Language/Behaviors	9
		Maladaptive Mood	7
		Maladaptive Substance Use	6
		Neutral Clothing	4
		Maladaptive Thoughts	3
		Adaptive Active Participation	3

Table 4. Frequencies of theme responses: MSE

4.8 Presenting Concern

Participants identified maladaptive occupational difficulties (10) as the first theme for the Euro-American. Maladaptive occupational theme is exemplified by text submissions such as “missed work” or “had anxiety when applying for job.” The second most frequent theme is maladaptive sleep or tiredness (7). The theme maladaptive sleep/tiredness was supported by submissions such as difficulties sleeping, or lack of sleep. The third most frequent theme for the Euro-American client is maladaptive romantic relationship difficulties (5). An example of a submission supporting maladaptive romantic relationship is that “his girlfriend Wendy dumped him.” The fourth most frequent theme is maladaptive mood (5). An example of maladaptive mood is depressed mood or feelings of listlessness.

Participants identified maladaptive occupational difficulties (20) as the most mentioned theme for the Alaska Native. Two examples of submissions that supported the maladaptive occupational theme are “lost job” and “fired from his job as a cook.” The second most frequently mentioned theme is maladaptive sleep or tiredness (19). An example of maladaptive sleep/tiredness is delayed sleep onset and difficulty staying asleep. The third theme is maladaptive romantic relationship (10). An example of a text submission that supports the theme of a maladaptive romantic relationship is “girlfriend broke up with him” and “break-up with his girlfriend.” The fourth theme is maladaptive substance use (6). Two submissions that express the theme of maladaptive substance use are “drinking 2-3x a week” and “drinking 2-4 shots of Jack Daniels.” The fifth theme is maladaptive social difficulties (4). An example of a text that identifies maladaptive social difficulties is “being a hermit.” Maladaptive mood (3) is the sixth most frequent theme. An example of maladaptive mood is “he is depressed” or “he has been feeling down.” The seventh theme is maladaptive energy (3). An example of maladaptive energy is “laying around all day” or “low energy. Table 5 illustrates the responses for the Euro-American and the Alaska Native client’s presenting concern(s).

Euro-American Client Themes	Frequency	Alaska Native Themes	Frequency
Maladaptive Occupational	10	Maladaptive Occupational	20
Maladaptive Sleep/Tired	7	Maladaptive Sleep/Tired	19
Maladaptive Romantic Relationship	5	Maladaptive Romantic Relationship	10
Maladaptive Mood	5	Maladaptive Substance Use	6
		Maladaptive Social	4
		Maladaptive Mood	3
		Maladaptive Energy	3

Table 5. Frequencies of theme responses: presenting concerns.

4.9 Client History of Treatment

Participants were next asked to identify in an unlimited text box what the client's history of mental health treatment was, if any. Participants reported no diagnosis (5) as the most frequent and only theme for the Euro-American client. Submissions that support the theme of no diagnosis are "none" or "first time client has been to counseling." Participants identified no diagnosis (8) as the most frequent, and only, identified theme. The theme of diagnosis was supported by submissions such as "no hx of mental health tx" or "first time seeking services." No other themes were identified for either the Euro-American or the Alaska Native client, as related to the client's history of mental health treatment. Table 6 illustrates the responses for the Euro-American and the Alaska Native client's mental health treatment history.

Euro-American Client Themes	Frequency	Alaska Native Client Themes	Frequency
No Diagnosis	5	No Diagnosis	8

Table 6. Frequencies of theme responses: mental health treatment history.

4.10 Client History

Participants identified maladaptive substance use (16) as the most frequent theme for the Euro-American client. Examples of submissions that represent maladaptive substance use are “3-4 shots of whiskey” and “several beers a week.” Maladaptive sleep (5), maladaptive romantic relationships difficulties (5), and adaptive cooking (5) were identified as the second themes for the Euro-American client, with the same frequency for each of these themes. Maladaptive sleep is exemplified by “oversleeping” and “takes a sleep aid.” An example of a submission supporting a maladaptive romantic relationship is “girlfriend left unexpectedly 6 months prior.” The third theme is maladaptive occupational functioning (4) and maladaptive social difficulties (4). An example of a submission that supports the theme of maladaptive occupational functioning is “anxious about finding a job.” An example of a submission that supports maladaptive social functioning is “apprehensive around people” or “limited social network.” The forth theme for the Euro-American client’s history is both “maladaptive father relationship difficulties” (3) and “adaptive mother relationship” (3). The submissions “difficult relationship with father” and “contentious relationship with his father” support the theme of maladaptive father relationship. An example of two

submissions that support the theme adaptive mother is “very close to mother” and “close relationship with mother.”

Participants identified maladaptive substance use (12) as the most frequent theme for the Alaska Native. Two submissions that support the theme maladaptive substance use are “6 alcoholic drinks per week” and “drinking 3 sessions a week.” Maladaptive occupational functioning (7) is the second most frequently mentioned theme. An example of a submission that supports the maladaptive occupational functioning is “fired from his job.” The third most frequently identified theme is adaptive mother relationship (6). Two examples of submissions supporting adaptive mother relationship are “being able to confide in her (mother)” and “feels close to mom.” The fourth theme for the Alaska Native client is maladaptive brother relationship difficulties (5). Maladaptive brother relationship was supported by submission such as “they have grown apart” and “brother who is more traditional doesn’t understand his way of life.” The location of the client’s neutral residence (4) is the fifth theme. Participants reported this theme by text submission, such as “moved to Fairbanks 3 years ago” and “client has lived in Fairbanks most of his life.” Maladaptive father relationship difficulties (3), maladaptive sleep difficulties (3), and maladaptive isolation (3) represent the sixth themes. Maladaptive father relationship was identified by participants submissions such as “distant relationship with father” and “doesn’t get along with his dad.” Table 7 illustrates the responses for the Euro-American and the Alaska Native client’s history.

Euro-American Client History Themes	Frequency	Alaska Native History Themes	Frequency
Maladaptive Substance Use	16	Maladaptive Substance Use	12
Maladaptive Sleep	5	Maladaptive Romantic Relationship	7
Maladaptive Romantic Relationship	5	Adaptive Mother Relationship	6
Adaptive Cooking	5	Maladaptive Brother Relationship	5
Maladaptive Occupational	4	Neutral Client Residence Location	4
Maladaptive Social	4	Maladaptive Father Relationship	3
Maladaptive Father Relationship	3	Maladaptive Sleep	3
Adaptive Mother Relationship	3	Maladaptive Isolation	3

Table 7. Frequencies of theme responses: client history.

4.11 Client Family History

Participants identified a maladaptive aunt's mental illness (7) as the Euro-American client's most frequently identified theme. This theme was supported by submissions such as "aunt went to Anchorage to see psychiatrist" and "aunt with previous diagnosed mental health illness and medication." The second most frequently identified theme is maladaptive father relationship difficulties (5). Statements that support the theme maladaptive father relationship are "feels disconnected to father," "dislikes father," and "is often insulted by him." The third theme for the Euro-American client is maladaptive romantic relationship difficulties (4). An example of a submission that supports a maladaptive romantic

relationship is “won’t talk to him when he goes by her (girlfriend) work.”

Maladaptive social difficulties (3), neutral brother identification (3), and adaptive mother relationship (3) are the fourth themes. An example of a submission that supports the theme of maladaptive social difficulties is “has a hard time interacting with people.” Neutral brother identification is exemplified by submissions such as “ brother (Bill) lives in bush” and “has a brother in his immediate family.” Two examples of a submission that supports the theme of an adaptive mother relationship are “close to mother” and “close to mother, referred to her as his best friend.”

Participants identified adaptive mother relationship (13) as the most frequently identified theme. This theme was supported by text submissions such as “Mother (Barbara) is more like me,” “lay low and do your own thing,” and “a close and supportive relationship with his mother.” The second most frequently identified theme is a maladaptive father relationship (11). An example of a submission that supported the maladaptive father theme is “Jerry describes his relationship with his father as conflicted.” A maladaptive brother relationship (8) is the third most reported theme for the Alaska Native client. This theme was supported through such statements as “characterizes his relationship with his brother as somewhat distant.” The fourth theme is a maladaptive aunt’s mental illness (7). Maladaptive aunt’s mental illness was supported by submissions such as “aunt with apparent mental illness,” “sent to see a shrink,” and “aunt received ‘happy pills’ she got much better, believes she was being treated for depression.”

The fifth themes identified for the Alaska Native client is neutral brother residence location (3) and maladaptive father traditional (3). The theme neutral brother residence location is exemplified by submissions such as “brother lives in the bush” and “brother is out in the bush.” Maladaptive father traditional is identified through submissions such as father (John) is “more like my brother-traditional,” “work hard,” “he thinks I am lazy,” and “father is strict and traditional.” Table 8 illustrates the responses for the Euro-American and the Alaska Native client’s family history.

Euro-American Client Family History Themes	Frequency	Alaska Native Client Family History Themes	Frequency
Maladaptive Aunt Mental Illness	7	Adaptive Mother Relationship	13
Maladaptive Father Relationship	5	Maladaptive Father Relationship	11
Maladaptive Romantic Relationship	4	Maladaptive Brother Relationship	8
Maladaptive Social	3	Maladaptive Aunt Mental Illness-TX	7
Neutral Brother Identification	3	Neutral Brother Residence Location	3
Adaptive Mom Relationship	3	Maladaptive Father Traditional	3

Table 8. Frequencies of theme responses: client family history.

4.12 Physical Health

Participants identified maladaptive tired or sleep (4) as the most frequent, and only, theme. The theme maladaptive tired/sleep was supported by submissions such as “describes feeling tired all of the time” and “poor sleep pattern.”

Participants identified adaptive physical health (4) as the most frequently mentioned theme for the Alaska Native client. This theme was supported by submissions such as “no major concerns” and “client appears to be in good physical health.” Maladaptive back pain (3), maladaptive substance use (3), and neutral pain medication (3) represent the second most frequently reported themes. The theme maladaptive back pain is supported by submissions such as “reports back pain from an accident” and “takes pain medication for back pain.” An example of submissions that supports the theme of maladaptive substance use are “drinks alcohol 2-3 times per week,” “2-3 standard drinks per time.” The theme neutral pain medication was supported by text submissions such as “takes pain medication for back pain and mentions an accident that he had which causes him to take back pain”. Table 9 illustrates the responses for the Euro-American and the Alaska Native client’s physical health.

Euro-American Physical Health Themes	Frequency	Alaska Native Physical Health Themes	Frequency
Maladaptive Tired/Energy Low	4	Adaptive Physical Health	4
		Maladaptive Back Pain	3
		Maladaptive Substance Use	3
		Neutral Pain Medication	3

Table 9. Frequencies of theme responses: client physical health.

4.13 Quantitative Results

Percentages are presented for diagnosis, diagnosis extremities, and GAF scores utilizing the multi-axial diagnosing system set forth in the DSM-IV-TR (APA, 2000). The multi axial system, according to the DSM-IV-TR, enables the counselor to asses their clients over multiple domains. The domains are represented over five axes, according to the DSM-IV-TR, these are “Axis I, clinical disorders and other conditions that may be a focus of clinical attention, Axis II personality disorders and mental retardation, Axis III general medical conditions, Axis IV psychosocial and environmental problems and Axis V global assessment functioning” (2000).

4.14 AXIS I- Clinical Disorders

Of the participants who viewed the Euro-American and Alaska Native client intake session, 80% identified at least one diagnosis on Axis I. Table 10 illustrates participants whom diagnosis on Axis I.

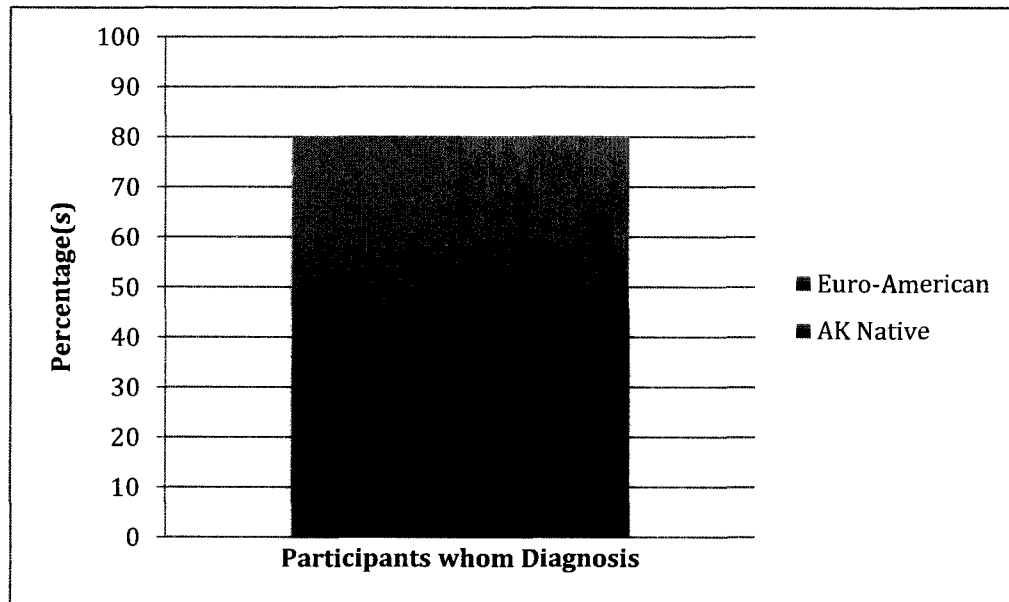


Figure 3. Frequency of participants diagnosed on Axis I.

Of the diagnosis provided for the Euro-American client, 37.5% reported a diagnosis of Major Depressive Disorder; 25% of the diagnoses were Social Phobia; 25% of the diagnoses were Insomnia; and 12.5% of the diagnosis was Mood Disorder, Substance Induced, with depressive features, mild.

Of the seven participants who viewed the Alaska Native client, 80% diagnosed the client with at least one diagnosis on Axis I. Of the 80% of participants who identified a diagnosis, 16.66% identified four diagnoses for the Alaska Native client. Of the diagnosis reported for the Alaska Native client, 33.33% were Major Depressive Disorder; 33.33% of the diagnoses were Adjustment Disorder; 11.11% were specific phobia; 11.11 % insomnia diagnosis;

and 11.11% alcohol abuse diagnosis. Figure 4 illustrates participants whom diagnosis on Axis I.

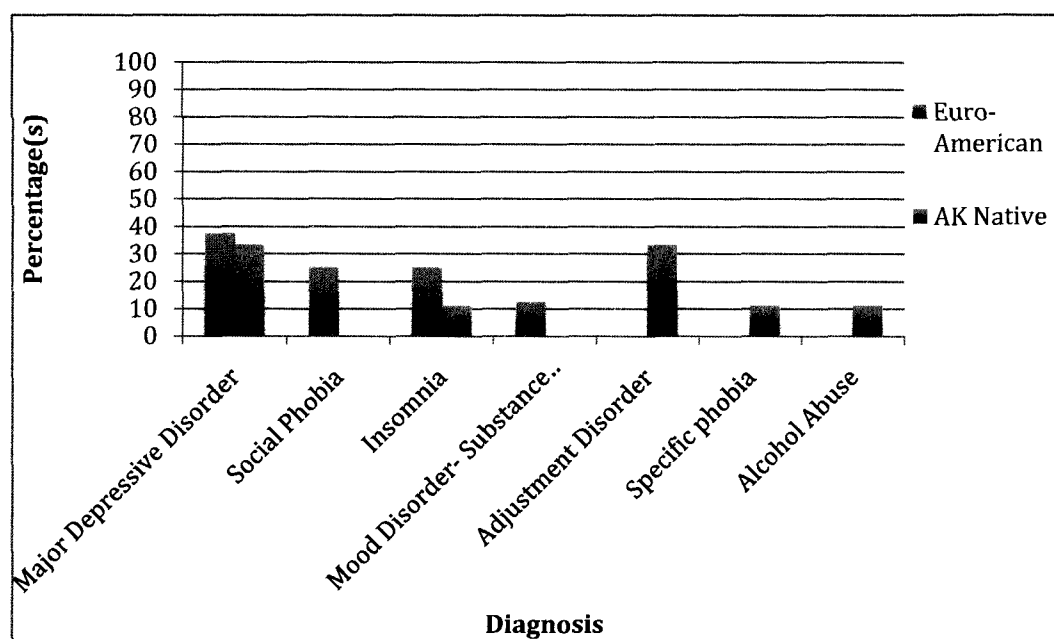


Figure 4. Axis I diagnosis

4.15 AXIS II- Personality Disorders and Mental Retardation

Of the participants who viewed the Euro-American client's mock mental health intake, 100% of the participants identified no diagnosis on Axis II. The participants who viewed the Alaska Native client's mock intake video session all reported no diagnosis. Figure 5 illustrates participants whom diagnosis on Axis II.

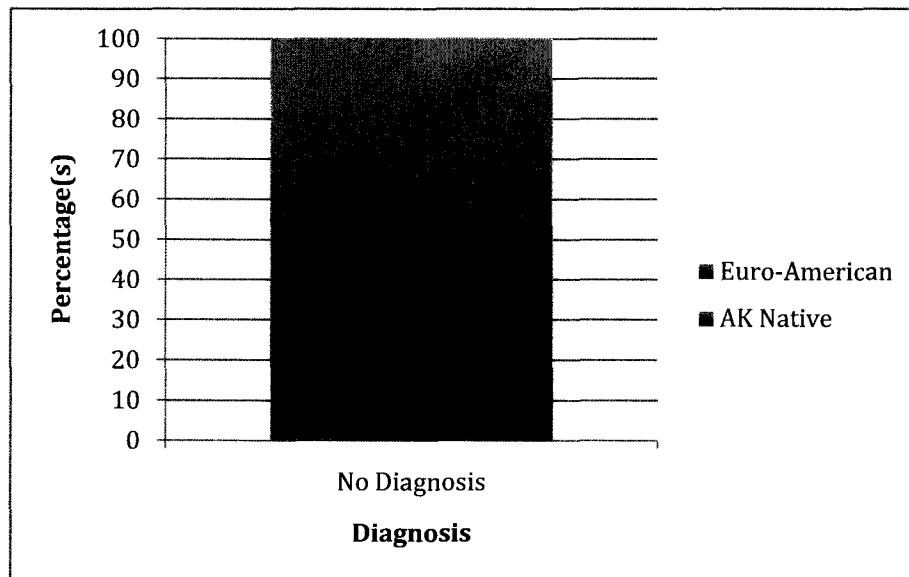


Figure 5. Axis II diagnosis

4.16 AXIS III- General Medical Conditions

20% of participants who viewed the Euro-American client's mock intake session reported a diagnosis on Axis III. 57% of participants who viewed the Alaska Native client identified a diagnosis on Axis III. Figure 6 illustrates participants whom diagnosis on Axis III.

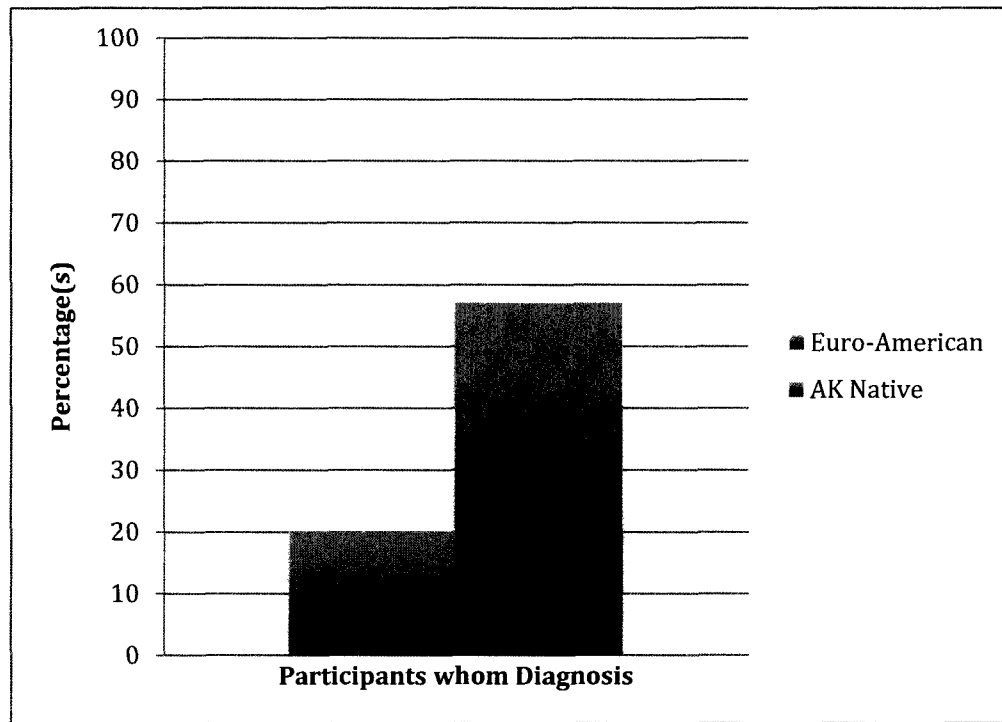


Figure 6. Frequency of participants diagnosed on Axis III.

Of the 20% of participants who provided a diagnosis, for the Euro-American client, 100% of the diagnosis was back pain. Of the diagnosis identified for the Alaska Native client on Axis III, 75% reported a back pain, while 25% reported a diagnosis of insomnia. Figure 7 illustrates diagnosis on Axis III.

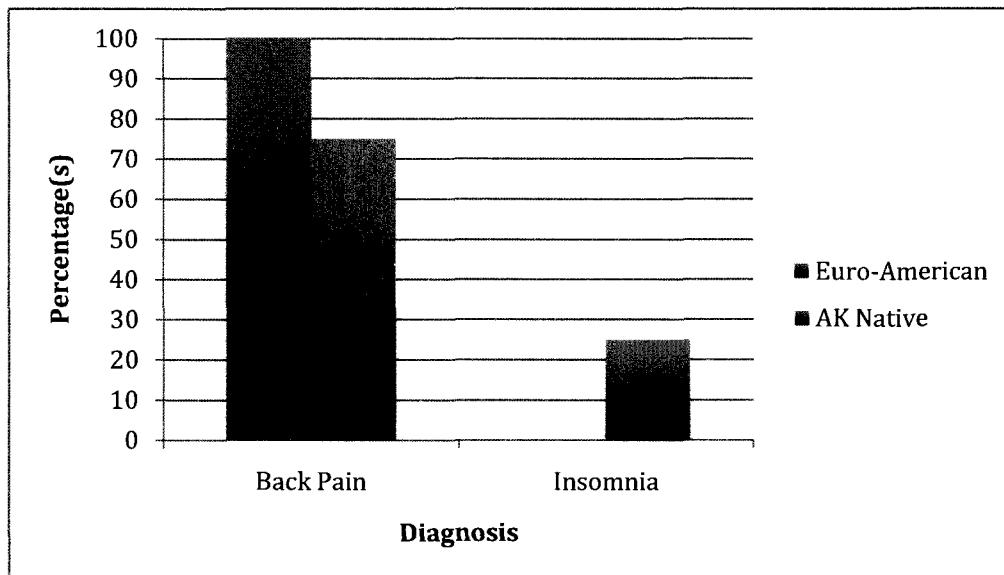


Figure 7. Axis III diagnosis.

4.17 AXIS IV-Psychosocial and Environmental Problems

Of the participants who viewed the Euro-American client's mock intake video, 80% of the participants provided a description of psychosocial and environmental problems. Of those participants who viewed the Alaska Native client's mock intake video, 71.42% of the participants identified psychosocial and/or environmental problems. Figure 8 illustrates participants whom diagnosis on Axis IV.

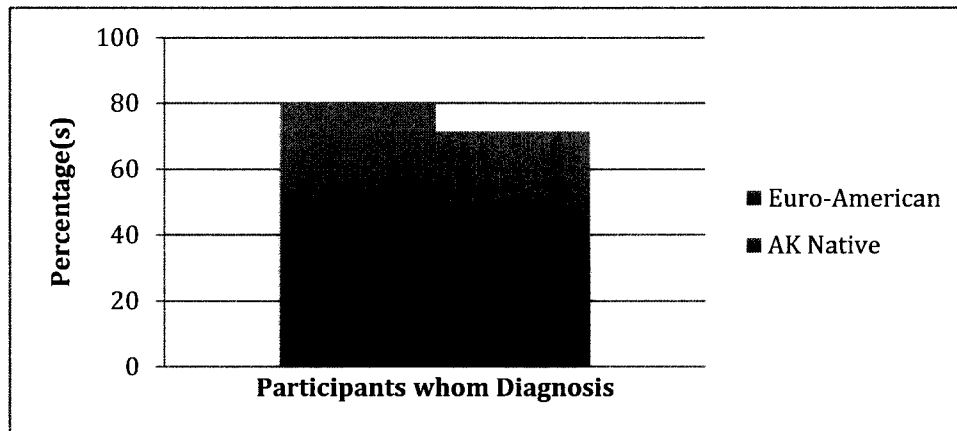


Figure 8. Frequency of participants diagnosed on Axis IV.

Of the participants who identified psychosocial and environmental problems for the Euro-American client, 33.33% were maladaptive occupational; 20% maladaptive social; 13.33% maladaptive romantic relationship; 13.33% maladaptive financial; 13.33% maladaptive residence; and 6.66% maladaptive primary support.

Of the participants who identified psychosocial and/or environmental problems for the Alaska Native client, counselors reported 27.27% as being maladaptive social; 18.18% as being maladaptive occupational; 18.18% as being maladaptive financial; 18.18% as being maladaptive primary support; 9.09% as being maladaptive romantic relationship; and 9.09% as being maladaptive depressed mood. Figure 9 illustrates diagnosis on Axis IV.

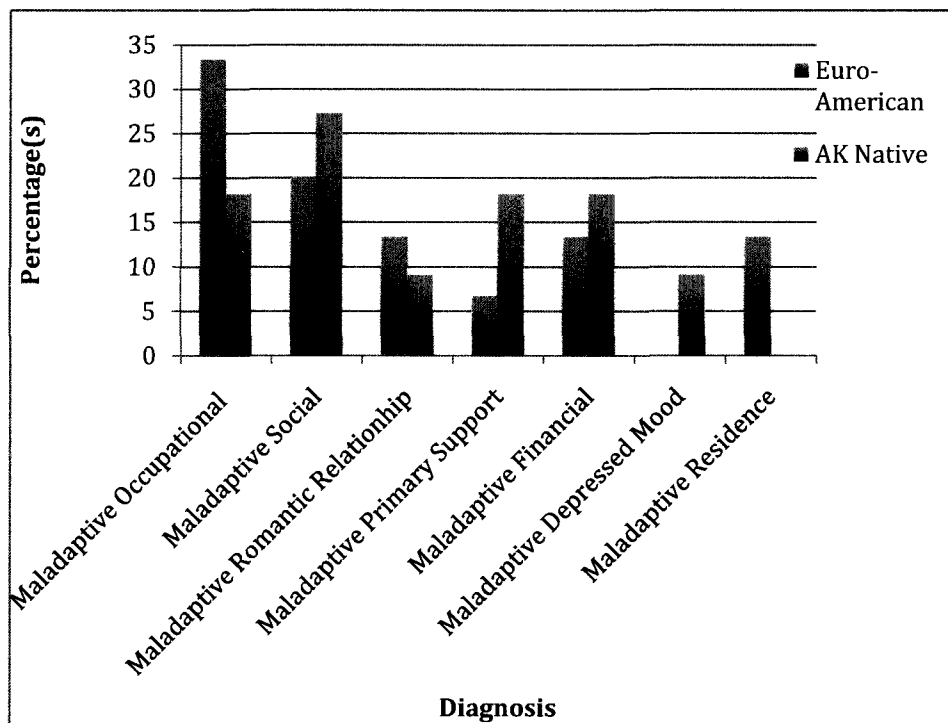


Figure 9. Axis IV diagnosis.

4.18 AXIS V- Global Assessment of Functioning Score

Of the participants who viewed the Euro-American client's mock intake video, 80% provided a GAF score; 71.42% of participants who viewed the Alaska Native client provided a GAF score. Figure 10 illustrates participants whom diagnosis on Axis IV.

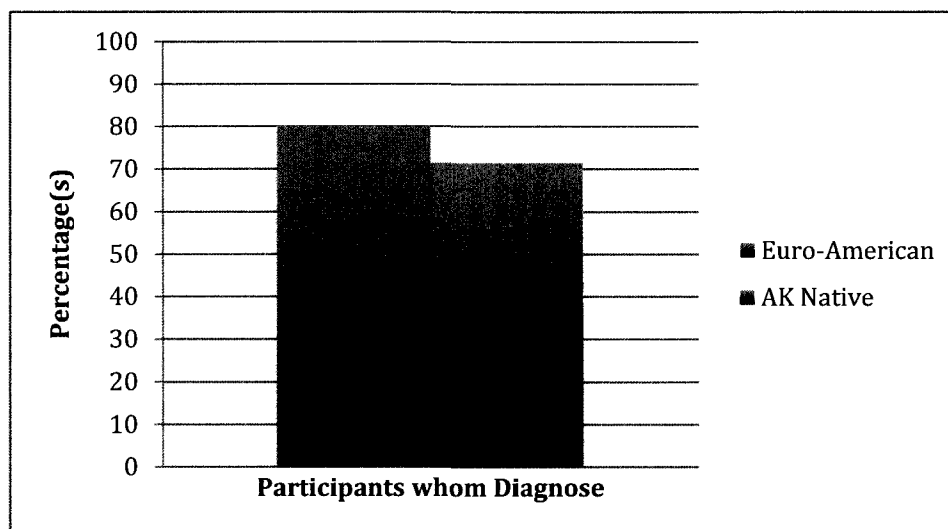


Figure 10. Frequency of participants diagnosed on Axis V.

A two-tailed t-test for independent means was executed to determine statistical significance of the mean of GAF scores provided for the Euro-American and Alaska Native client. There was a significant difference in GAF scores, $t(7) = 2.42, p = .044 [d = 1.62]$, with the Euro-American client receiving higher GAF scores than the Alaska Native client. Participants who viewed the Euro-American client condition ($M = 65.5, SD = 6.45$) on average reported a higher GAF score than the participants who viewed the Alaska Native client, condition ($M = 54.3, SD = 7.29$). The results support the hypothesis that with all else being equal, the Euro-American client received a statistically significant higher mean GAF score than the Alaska Native client.

In conclusion, counselors-in-training identified differences in assessment and diagnosis of the Euro-American and Alaska Native client. Differences are present in the results in both the theme types, throughout the written portion of the

assessment as well as types of diagnoses on four out of five of the axes, in the multi axial diagnostic system. Chapter five discusses the results, identified in this chapter. Chapter five includes discussions related to; research, training, and diagnostic implications of the results.

Chapter Five

Discussion

The results of the current study support the quantitative hypothesis that counseling students would, view an Alaska Native client as more maladaptive than a Euro-American client. They expressed this through more frequent diagnosis and lower mean GAF scores for the Alaska Native client. Not only did students diagnosis more frequently and provide lower GAF score they were also less successful at recalling demographic information about the Alaska Native versus the Euro-American.

This research utilized a software program to randomly distribute participants to either the Alaska Native or Euro-American video. The gender of participants was in the end of data collection not evenly distributed between the two conditions. A post-hoc t test was done, at the direction of a committee member, to determine if gender differences were a casual factor for the results. The post hoc t test was done on axis V, GAF score, as this axis identifies the overall level of functioning of the individual. The post hoc t test results $t(7) = p < .375$ supports that differences in this sample are not due to gender. Perhaps future research could choose to focus on gender differences in diagnosis, however this was not the purpose of the current research.

It is important to remember while reading this chapter that both of the videos were purposefully created and filmed as similarly as possible, in order to see if differences persisted in diagnosis for the Euro-American and Alaska Native

client. Purposefully, the actors hired were males who were not pursuing theater as an interest or undergraduate emphasis. Male actors were recruited by contacting both the Psychology department and Rural Students Services department, at the University of Alaska Fairbanks (UAF). A request went out announcing a paid acting position for a Euro-American male and an Alaska Native male age 19.

The first two males who met the criteria and identified an interest in acting in the videos were chosen to be clients in the mock mental health videos. Both male actors identified, pre-filming, that they were students at the University of Alaska Fairbanks, enrolled in an undergraduate program, not theater related. The actors were instructed to wear a dark colored t-shirt and casual pants during filming of the video in order to minimize visual difference of the actors. The mock mental health videos were filmed in the same mental health office, in order to ensure that stimuli in the background of the videos were the same. The videos were filmed with the same camera angle and chair position for both videos. Both male actors spoke the exact same scripted mental health session, and were instructed to be as natural as possible while delivering the scripted text.

While efforts were made to diminish differences in the videos created, there are a few areas that vary. The areas that varied, based on the natural delivery of the script by the actors, were language patterns, facial expressions, and body language. One of the natural differences in the mock intake session was the language pattern each actor naturally expressed. Language patterns include such things as rate, clarity, and tone of speech. The Euro-American actor's video lasted

21 minutes and 34 seconds while the Alaska Native actor's video was 21 minutes and 40 seconds in duration, a difference of six seconds for rate of speech. The tone of the Euro-American and Alaska Native actor varied somewhat, however, the overall tone of both actors stayed within expected ranges. Neither actor raised his tone to an audible level, similar to a yell, nor did they lower their tone, as to not be audible.

Each of the actors was instructed to be as natural as possible throughout the video, which resulted in varied body language and facial expressions exhibited by each. Body and facial language include such things as facial expressions, arm movement, and general body movement. The Euro-American actor displayed, naturally, more varied movement and facial expressions. The Alaska Native actor displayed, naturally, less frequent facial expression changes and less body movements.

5.1 Limitations

This research concluded with a small sample size. Future research can aim to achieve a larger sample size. Researchers may want to engage participants who are at different stages of their counseling careers, for example, counselors in training, one-year post graduation and licensed professionals, this information could add to the body of literature available which could benefit educators and professionals.

While this research resulted in differences for the Euro-American and Alaska Natives, mental health diagnosis, there are some limitations to the current

study. This research utilized male actors in the mock mental health videos. Therefore, this research did not identify the similarities or differences that may exist, diagnostically, for female clients who vary in ethnicity. Future researchers may want to incorporate actors who are female.

At times graduate students take courses out of sequence while enrolled in their prospective program. This research is limited due to the possibility that some students may have not completed a psychopathology course prior to participating in this study. The omission of this course from the participants knowledge system, may impact the diagnosis provided for the client's in the present study.

The participants in the current study were not exposed to the intake form prior to viewing the videos. This may have impacted the participant's ability to document information about the clients, as they would in normally in the counseling setting. Future research may want to enable participants to either view the intake form prior to viewing the videos or for the participants to have access to the intake form while viewing the videos.

Graduate students enrolled in counseling programs are prompted to pursue one of two educational tracks in their program. One track is for students who desire to go on and conduct counseling services the other track enables students to work as school counselors. Participants in the present study were not asked which academic track they were enrolled in. Participants in the current study who were not pursuing the counseling academic track may have limited knowledge in diagnosis, which potentially could have impacted the assessments provided by the

students.

5.2 Client Demographics

Intake forms have an area for counselors to fill out demographic information pertaining to their client. This section describes the results of the demographic portion of the intake form; name, age and gender. This section highlights the differences in counselor trainee's ability or memory to report demographic information, when exposed to a Euro- American versus an Alaska Native client.

5.3 Client Name

All intake forms provide an area for the counselor to identify the client name. It is a requirement for the counselor to be able to provide the client's full name in order to ensure proper paperwork, abide by insurance companies billing requirements, and build a therapeutic bond. The client's name in the mock mental health video is Jerry Caruk. During the mock mental health intake session video, the counselor said the client's first name, Jerry, three times and said Mr. Caruk, one time. The client said his full name, Jerry Caruk, one time.

The most frequently identified theme, for both clients, is his full name, Jerry Caruk. However, when percentages are done on these results they identify that 80% of the participants were able to recall the full name of the Euro-American client, while 57.14% of participants who viewed the Alaska Native client were able to recall his full name.

The experience of effective name recall for the Euro-American Jerry, while flawed, is decidedly different than the Alaska Native Jerry's experience of name recall. A plausible phenomenon that is impacting the difference in name recall may be ethnocentric monoculturalism. Ethnocentric monoculturalism, as discussed in chapter two of this research, is defined by Sue et al. (1999) as "The invisible veil of a worldview that keeps white Euro-Americans from recognizing the ethnocentric basis of their beliefs, values, and assumptions" (p. 766).

Counselors-in-training who self identify as Euro-American or identify a Euro-American based worldview may experience increased likelihood of differences in demographic retention, as well as differences in diagnosis of clients who differ in ethnicity.

Euro-American counselor trainees would experience the Euro-American client as a part of their in-group. In-group according to Baron, Byrne and Branscombe (2006) is the group that a person identifies they belong to (2006, p. 233). Counselor trainees who identify the Euro-American client as part of their in-group and are unaware of the ethnocentric values and beliefs of their Euro-American culture, may be much more likely to retain a fellow Euro-American's name versus a minority person's name.

Recognizing and understanding one's beliefs, values, and assumptions requires attention and intent in order to honestly know one's self. Additionally, understanding how those values, beliefs, and assumptions manifest and are executed in daily life, knowingly or unknowingly, adds another layer for

counselor trainees to contend with during their quest of self-awareness.

The name-recall results may support the need for future research to be conducted that (a) identifies the best way (s) for counseling programs to ensure trainees are aware of personal values, beliefs, and/or assumptions they have; (b) identifies whether participation in counseling, as a client, assists in personal awareness, for counselors-in-training; (c) identifying the experience that a client has when they are made aware that their counselor trainee is unable to recall their name; and lastly, (d) provides graduate students with practical and practiced name recall skills.

Counselor trainees can benefit from learning and memorizing their client's name and names of their client's relevant friends, family, and co-workers, as it is helpful in the quest of effectively bonding with their client(s). Helping graduate students become aware of the meaning(s) a client places on the lived experience of having their counselor easily able to recall the name or the names of those the client cares about is important for counselors-in-training to understand. Training programs may want to consider teaching their students skills to improve their name recall strategies. Neuschatz et al. (2005) concurred that people can improve their name recall skills by paying attention, rehearsing, and associating the information with something else.

These results identify that participants who have completed 50-350 face-to-face hours with clients, are able to recollect the Euro-Americans full name 80% of the time, while the Alaska Native, has his full name recollected 57.14% of the

time. Both clients will experience the realization their counselor-in-training does not know their name. The Alaska Native will experience the realization that his counselor-in-training does not know his name more than the Euro-American will experience. This increases the likelihood that the therapeutic bond will be injured, for both clients, but the therapeutic bond with the Alaska Native client is in more jeopardy. The difference in graduate students ability to recall an Alaska Native's name versus a Euro-American's name may represent ethnocentric monoculturalism, white privilege, or racism.

The inability to recollect a client's name can negatively impact the therapeutic relationship. The inability to recollect a client's name may be interpreted by the client in a multitude of ways, such as: the counselor does not care or they, the client, are not important. Most people identify with their name and use it, in part, to differentiate themselves from others. The graduate students inability to recollect their client's name may be rationalized by the client in many ways.

In conclusion, it appears that with all else being equal in the videos, this data identifies that counselors-in-training, housed at UAF, UAA, or APU are more likely to recall a Euro-American males full name versus an Alaska Native males full name by the conclusion of session one. Name recall is not equal for the Euro-American Jerry and the Alaska Native Jerry.

5.4 Client Date of Birth

Participants were asked to identify the client's date of birth. Similarly to the client name, most intake forms provide an area for the counselor to identify the client's date of birth. The client's date of birth provides a counselor with valuable information related to the client's current developmental stage.

Clinicians who support Erik Erikson's eight stage lifespan development theory, would be able to assess their client's development over the following stages: basic trust versus mistrust, autonomy versus shame and doubt, initiative versus guilt, industry versus inferiority, identity versus identity confusion, intimacy versus isolation, generativity versus stagnation and ego integrity versus despair (1975, p. 314). The ability to identify the stage of development a client is experiencing can assist the counselor in forming their diagnosis and treatment plan.

Furthermore, by knowing the client's age, counselors can understand the cultural ceremonies or practices that are relevant in their client's development. As mentioned earlier, some Yup'ik males identify to become a man in their culture they must kill a bearded seal (Frink, 2009). Counselors must understand this necessary rite of passage for the Alaska Native clients who identify this as a part of their culture. Without date of birth information, it increases the likelihood that counselors-in-training may be uncertain of the client's current developmental stage, and what rites of passage they may desire to experience.

Once during the mock session, Mr. Caruk identified his age to be 19 years old. The client did not disclose a specific day, month, or year of his birth date

during the session. The year both mock videos were created and provided to participants for participation in the present study was 2010. During both intake sessions, the client reports being age 19 at the date of his intake session, resulting in his birth occurring during the year 1991.

Of the participants who viewed the Euro-American, 100%, reported the accurate year of birth, 1991. Of the participants who viewed the Alaska Native intake session, 57.15% were able to accurately identify the accurate year of birth, 1991, or the chronological age, 19. 42.85% of the participants who viewed the Alaska Native video were unable to recall any information related to the Alaska Natives date of birth.

These results identify that every participant took the time to mathematically figure out the correct year of birth for the Euro-American. The participants, who viewed the Alaska Native, were able to accurately identify his date of birth, 57.14% of the time. Future research could be done in this area to discover (a) if other non-majority clients will experience minimized effective date of birth recall from their counselors-in-training; (b) relevant math training skills for graduate students; and (c) personal values, beliefs, and assumptions that impact a counselor trainees ability to recall a client's date of birth.

In conclusion, it appears that with all else being equal in the videos, this data identifies that counselors-in-training are much more likely to recall the Euro-American client's date of birth versus the Alaska Native client's date of birth at the end of session one. Date of birth is not equal for the Euro-American and the

Alaska Native client.

5.5 Client Gender

During the scripted videos, the client identified he was male by stating, “ I am a male.” Of the participants who viewed either the Euro-American or Alaska Native, 100% of participants accurately identified the client gender as male. This means that both the Euro-American and Alaska Native can be confident that their counselor-in-training can accurately report his gender.

In conclusion, with all else being equal in the mock mental health videos, no difference was identified for either pertaining to accurate gender identification.

Training programs should continue their efforts in this area.

5.6 Mental Status Exam

Participants were asked to type their Mental Status Exam (MSE) assessment into a text box on the intake form. The text box allowed the participants unlimited space to write their MSE assessment. The MSE is an assessment tool that is implemented by most counselors during the first counseling session, called an intake, but can be utilized by a counselor at any point during the counseling process.

The MSE enables the counselor to assess the client, typically over the following nine areas: physical appearance (clothing, ethnicity, body type); behavior/psychomotor (agitated, fidgeting); attitude towards counselor (resistant, active participation); affect/mood (congruent mood to topic, flat mood/affect); speech/thought (rate of speech, congruent cognition); perceptual disturbances

(hallucinations, delusions); orientation to person, place, and time (president, current location, time of day); memory/intelligence (count back from 100 by seven, remember list of words); and judgment/insight (what would you do if you find a stamped envelope?) (Pomerantz, 2008).

The script that both actors adhered to identified the following scripted text to address the nine categories in the MSE;

(1) Physical appearance: Both actors were instructed to wear similar clothes, dark t-shirt and jeans. Both actors had a similar body type and short haircut.

(2) Behavior/psychomotor: Both actors were instructed to behave as normal as possible while reading the text. Neither actor was instructed to fidget or be oppositional during the filming of the video.

(3) Attitude towards counselor: The script did not include any text during the MSE, or intake script in general, that supported the client as being resistant or lacking participation. The client answered every question the counselor asked throughout the MSE and full intake session. The client was actively participating, demonstrated by his willingness to offer additional information and small talk.

(4) Affect/mood: The actors were instructed to be as normal as possible while reading the text.

(5) Speech: Each of the actors read the exact same script verbatim. No differences are present in terms of content.

(6) Perceptual disturbances: The MSE script identified multiple conversational points where the client demonstrated that he was not currently experiencing perceptual disturbances. The client was able to identify objects accurately, recall numbers accurately, and answered all questions appropriate to question content.

(7) Orientation to person, place, and time: Orientation to person occurs when the counselor asks, "OK then. To get things started what is your full name?" The client accurately identifies, "Jerry Caruk." Orientation to place is addressed in the script when the counselor asks the client to report where he is right now. The client responds accurately, "I am in your mental health office, downtown Fairbanks." In the script the counselor asks the client, "Can you tell me what year it is?" The client responds accurately, "2010."

(8) Memory/intelligence: During the MSE, the counselor asked the client, "Ok. Now I am going to tell you 3 words and I would like you to remember them and I will ask you to tell me them in a little while. Do you understand?" Later during the MSE, the client identifies that he agrees, and is able to do this memory

task effectively. The client is further scripted to identify the name of our current president, and to list as many words that begin with letter R in one minute. Since both the scripts are identical, the client is able to do each of these tasks effectively, devoid of difficulties.

(9) Judgment/insight: During the script the client is asked, “Now if you find a envelope and it is addressed and has a stamp, what should you do with the envelope?” The client responds, “Um, well, I guess put it in the mailbox or give it to a mailman.”

The most frequent theme identified for the Euro-American is adaptive cognitive capabilities (10); the most frequently identified theme for the Alaska Native is also adaptive cognitive capabilities (23). This means that both are identified to be optimally cognitively functioning. However, the Alaska Native’s theme of cognitive capabilities is supported more than double the theme for the Euro-American.

The second, and last, most frequently identified theme for the Euro-American is adaptive healthy/normal (4). The Alaska Native’s second most mentioned theme is maladaptive language/behaviors (9). This means that the counselors-in-training who viewed the Euro-American further support their most frequent theme of adaptive cognitive capabilities (10), with the second most identified theme being adaptive healthy/normal (4). These two themes reported for the Euro-American identify an overall high level of functioning on the MSE

portion of the intake form.

The Alaska Native, at the second level of themes, deviates from the Euro-Americans MSE themes to now include a maladaptive language/behavior theme (9). Submissions identify a maladaptive component to language and behavior for the Alaska Native by reporting statements such as “since he was very quiet it seemed that he might be going through a tough time.” This indicates that the counselors-in-training viewing the Alaska Native find that he is cognitively functioning optimally, but his speech patterns and physical behaviors are maladaptive, and thus impact his optimal functioning.

The third theme for the Alaska Native is maladaptive mood (7). The maladaptive definer is supported in this theme by submissions such as “looked very sad from time to time” or “depressed mood.” This means that although the counselors-in-training who assessed him heard the very same script, as did the counselors-in-training who heard the Euro-American, participants assessed the Alaska Native client with a maladaptive depressed mood that was impacting his functioning. No participants identified a maladaptive mood theme for the Euro-American.

The fourth most identified theme for the Alaska Native is maladaptive substance use (6). The maladaptive definer is supported by participant submissions such as “taking sleeping pills” or “6 alcoholic beverages a week.” This means that the counselors-in-training who viewed the Alaska Native identified that he was utilizing substances in a maladaptive way, resulting in

decreased functioning. No participants supported a substance use theme for the Euro-American.

Neutral clothing is the fifth most frequently identified theme for Alaska Native; two submissions identified adaptive clothing, while two other submissions identified maladaptive clothing, resulting in a neutral clothing theme. The rationale for a neutral theme is to express the differential reporting on physical appearance for the clients. The Alaska Native was assessed more often on physical appearance, but was not seen to have a dominant presence of either a adaptive or maladaptive component to his physical appearance. Submissions that either supported a maladaptive or adaptive definer are “client was dressed in a black shirt, which may imply he is not feeling very good about himself” (maladaptive) and “dressed appropriately” (adaptive). The Euro-American had no participants identify a maladaptive, adaptive, or neutral clothing theme.

Maladaptive thoughts (3) represent the sixth most frequently identified theme for the Alaska Native client. Participants supported the definer of maladaptive thoughts by submissions similar to “irrational beliefs.” This means that the counselors-in-training who viewed the Alaska Native identified an irrational belief system that impacts his functioning. The Euro-American had no participants identify a belief system, maladaptive, adaptive, or otherwise.

The seventh, and final, theme identified for the Alaska Native is adaptive active participation (3). Participants supported the adaptive active participation theme with a submission such as “engaged and willing to answer questions.” This

means that counselors-in-training, working with the Alaska Native, found him willing to actively participate in the counseling session. No participants identified a theme for the Euro-American related to participation of any kind.

Future research efforts could consider such research questions such as (a) What do counselors-in-training know and think about Alaska Native culture? (b) What values and beliefs do counselors-in-training have about Alaska Natives? (c) What do counselors-in-training know and think about Euro-American culture? (d) What values and beliefs do counselors-in-training have about Euro-Americans? (e) If counselors-in-training had specific set(s) of questions, and range of functioning scores for those questions to assess their clients, regardless of a client's ethnicity, would it influence or minimize the difference in assessment of MSE with varying cultural clients?

The Alaska Native actor's natural language patterns resulted in his video being six seconds longer than the Euro-American actor. The six additional seconds resulted in counselors-in-training identifying a maladaptive language and behavior theme as the second most frequently mentioned theme for the Alaska Native. Only six additional seconds were needed for counselors-in-training to identify a language rate difference. The identification of a maladaptive language and behavior pattern is present; this supports either (a) a bias exists within the counselors-in-training, or (b) the counselor trainees are unaware of language and behavior pattern differences that can occur across cultures.

It appears that counselor training programs may want to consider adapting the delivery or content of training related to the MSE. Counselors-in-training may benefit from extended knowledge relating to culture, such as language, behavior, affect, mood, gender, roles, values, and beliefs. Counselor trainees could benefit, should they choose, from a deeper understanding of similarities and differences that occur in presentation due in part to cultural variance. Counseling graduate students may benefit from further exposure to differing cultures than their own. Exposure and knowledge of the multitude of cultural values and presentations of those cultural values that people(s) possess, not only in Alaska, but all over the world, may improve counselors-in-training knowledge base, which could assist in their effective, culturally appropriate MSE assessment skills.

Lastly, training programs, may want to consider an evaluation tool that enables them to identify the cultural values the counselors-in-training adhere to in order to facilitate effective learning and exposure to cultures that graduate students may not have much information or experience with. An assessment tool could ideally be created that would assist in the identification of counselors-in-training who have a negative bias towards another person(s) due to their cultural orientation.

The results identify that the Euro-American and Alaska Native, with exact same script spoken, had one similar theme and multiple different themes on their MSE. The counselors-in-training who assessed the Euro-American identified that he is adaptively cognitively functioning, as well as healthy/normal. All themes

identified by counselor trainees' support that the Euro-American is functioning optimally on his MSE. The Alaska Native client's MSE assessment themes vary greatly from those of the Euro-American. The Alaska Native MSE assessment identifies two adaptive themes: adaptive cognitive capabilities and adaptive active participation. Both the Euro-American and Alaska Native were identified as possessing adaptive cognitive capabilities. The Alaska Native, however, is assessed as having four maladaptive themes on his MSE. The four maladaptive themes identified for the Alaska Native are; language/behavior, mood, substance use, and thoughts.

Counselors-in-training varied on the assessment they provided for the Euro-American and Alaska Native client, MSE. These differences identify how the graduate students are conceptualizing these clients. The mental conceptualization students have informs them of the presence, or lack of presence of diagnosis. At this point of the intake form, the Euro-American is optimally functioning; there are no themes that support a maladaptive component of his functioning. The Alaska Native is identified on his MSE assessment to not be optimally functioning. Not only did the counselor trainees find that the Alaska Native was not optimally functioning, but had more maladaptive themes than adaptive themes.

In conclusion, with all else being equal in the mock mental health videos, a difference exists in themes for the clients on the MSE assessment outcomes. The Euro-American is reported to be optimally functioning. However, while both

actors spoke the same script, the Alaska Native is identified to have a majority of maladaptive themes versus adaptive themes.

5.7 Presenting Concern

During the intake process, counselors-in-training were asked to identify their clients presenting concerns. Identification of a client's presenting concern often times includes a description of what the client is reporting the problem to be, as well as the components that impact or influence the presenting problem (Pomerantz, 2008). Participants were asked to provide the clients current presenting concern, or concerns, in a text box that allowed participants unlimited typing space to provide their assessment. The themes were subcategorized into either a maladaptive, adaptive, or neutral category for both the Euro-American and Alaska Native client.

During the video, the counselor inquires, "Can you tell me why you decided to come in and talk with me today?" The client responds, "Yes. Well, I have been having some difficulty sleeping. Recently split with my partner." The counselor goes on to explore the difficulties related to sleeping and his relationship, prior to moving on with the other intake sections. See Appendix G for further details of the mental health script.

The first three themes are the same for both of the clients. The most mentioned theme for both the Euro-American (10) and Alaska Native (20) is maladaptive occupation. Submissions that supported the maladaptive occupational theme are "missed work" or "anxiety when applying for job." This means that

despite differences in actors, counselors-in-training identified that the client is not optimally functioning in the area of his occupation. However, counselors-in-training identified that the Alaska Native is having less optimal functioning in the area of occupation than the Euro-American is experiencing.

The second most frequent theme is maladaptive sleep or tiredness (7) for the Euro-American, and maladaptive sleep or tiredness (19) for the Alaska Native. The theme maladaptive sleep/tiredness was supported by submissions such as “difficulties sleeping” or “lack of sleep.” This means that both the clients counselor trainee recognizes a presenting maladaptive concern related to their sleep patterns; however, the graduate students are almost three times as likely to identify a presenting concern in the area of sleep for the Alaska Native versus the Euro-American.

The third most frequent theme for the Euro-American is maladaptive romantic relationship (5). The third theme for the Alaska Native is also maladaptive romantic relationship (10). An example of a text submission that supports the theme of maladaptive romantic relationship is “girlfriend broke up with him” or “girlfriend (Wendy) dumped him.” This means counselors-in-training identified that both clients are experiencing difficulties in their romantic relationships; however, the participants reported maladaptive romantic relationship more frequently for the Alaska Native.

The fourth theme is the point where the themes differ in type, for the clients. The fourth most frequent theme identified for the Euro-American is maladaptive

mood (5). Submissions that exemplify the maladaptive definer of the maladaptive mood theme are “depressed mood” or “feelings of listlessness.” The forth theme for the Alaska Native is maladaptive substance use (6). The maladaptive definer in substance use is reflected by participant submissions such as “drinking 2-3x a week” and “drinking 2-4 shots of Jack Daniels.” This means that the Euro-American has been identified to have a maladaptive mood that impacts his optimal level functioning. The Alaska Native, however, has a maladaptive substance use pattern that is impacting his optimal functioning.

The fifth theme for the Alaska Native is maladaptive social difficulties (4). A submission that supports the maladaptive definer is “being a hermit.” This means that while the Euro-American no longer has any other presenting concerns identified, the Alaska Native is identified to have maladaptive functioning based on the experience of social difficulties.

The sixth theme for the Alaska Native is maladaptive mood (3). An example of a submission that reflects the definer and theme of maladaptive mood is “he has been feeling down.” This means that the Alaska Native is assessed as experiencing a decrease in functioning related to his maladaptive mood.

The seventh, and final, theme for the Alaska Native is maladaptive energy (3). A submission that supports the definer and theme of maladaptive energy is “laying around all day” or “low energy.” This means that despite the exact same text being reported the counselor trainees who viewed the Alaska Native is assessed to display maladaptive energy resulting in less than optimal functioning,

while the Euro-American did not.

Researchers can aim to understand the phenomenon of difference related to presenting concerns for the clients by asking future research questions: (a) what do counselors-in-training identify as the point of difference that results in the Alaska Native receiving an assessment of maladaptive substance abuse, when the Euro-American did not? (b) What values, beliefs, or assumptions do graduate students possess that results in the Alaska Native receiving more maladaptive themes than the Euro-American?

The Alaska Native had three additional themes than the Euro-American did. The Alaska Native was identified to have maladaptive substance use and maladaptive energy, while the Euro-American is not assessed as experiencing these presenting concerns. Graduate programs endeavoring to educate students may want to consider including further skills that enable students to effectively identify their clients presenting concern as well as exposure to many cultures.

Students in Alaska based programs may benefit from exposure and knowledge related to Alaska Native values, beliefs, language patterns, and facial features. Knowledge and exposure may benefit students, so that when they work with clients, they are able to identify what normal language patterns, normal facial features, normal behavior patterns, and normal thoughts are, for that client's culture. The above ideas may be useful if this phenomenon is explained by the lack of knowledge and lack of experience graduate students may have with people(s) who vary in ethnicity.

Furthermore, graduate students need additional exposure to Euro-Americans as well. If graduate students are assessing Euro-American clients as healthy or without problems, based on the fact they are Euro-American, those clients will suffer as well, because their problems will not be validated or addressed. It is possible that some students are unaware of the invisible veil or values they adhere to. Therefore it is important for counseling programs to assist students in their personal exploration of self, in order to minimize the likelihood that student's values or biases hurt their clients.

If counseling students have preexisting stereotypes or biases that are the cause of the difference in identification of presenting concerns for the Euro-American and Alaska Native, the above strategies may help, but further exploration needs to occur. Programs may be able to assist students by implementing in depth discussions and self-reflective papers related to student's personal values of person(s) of a different cultural orientation than themselves. If students are not able to identify their biases and discuss them, it certainly increases the likelihood that mental health services will lack, at the very least.

Faculty working in counseling programs may want to consider encouraging graduate students, certainly those who are identified as possessing bias, to participate in personal therapy, for a portion or all of the time they are enrolled in their graduate programs. Therapy can benefit counselor trainees, as it provides a confidential setting for them to process their culture, which can include but not limited to the values and potential biases that can influence their academic and

counseling practices.

The treatment plans are based on the presenting concerns area of the intake form. It is this area where counselors identify the problem(s) they are going to work on during therapy with the client. Intake forms are used to identify, in descending order, the problems the client is presenting. While counselor trainees identified four themes for the clients that were the same, the rates at which those themes were reported differ. The graduate students supported the presenting problem themes for the Alaska Native much more frequently in comparison to the Euro-American. This means that although both of the clients will receive treatment for maladaptive occupational, sleep/tiredness, mood, and romantic relationship, the Alaska Native themes are supported at a higher frequency of identification of these presenting concerns, in three out of those four themes. The Euro-American has a maladaptive mood theme, as does the Alaska Native. The Euro-American is identified to have more frequent submissions identifying a maladaptive mood than the Alaska Native.

Themes deviate for the Euro-American and Alaska Native at this point. The Euro-American has no other presenting concerns identified by participants. The Alaska Native, however, has presenting concerns of maladaptive substance abuse, social difficulties, and maladaptive energy. In the clinical setting, this may result in counselors-in-training focusing some portion of treatment efforts towards improving the Alaska Native's maladaptive presenting concerns of substance abuse, social difficulties, and energy. The counselors-in-training would not focus

on those maladaptive themes for the Euro-American, omission of these in treatment may impact the client negatively. The treatment experience would vary greatly based on the differences identified in presenting concern(s) for the Euro-American and Alaska Native client.

In conclusion, with all else being equal in the mock mental health videos, differences exist for the Euro-American and Alaska Native related to identification of presenting concern(s). The Euro-American is identified as having four maladaptive presenting concerns: occupational, sleep/tiredness, mood, and romantic relationship, while the Alaska Native is identified as having seven maladaptive presenting concern(s): occupational, sleep/tiredness, mood, romantic relationship, substance abuse, social difficulties, and maladaptive energy.

5.8 Treatment History

Participants were provided an unlimited text box to provide an assessment of the client's history of mental health treatment. Most intake forms provide counselors an area to report the client's historical mental health treatment. The information counselors can glean from conducting an in depth discovery of their new client's mental health history can prove very valuable. If counselors are unaware of a preexisting mental health diagnosis, substance abuse treatment or previous experiences with any mental health treatment, it may increase the likelihood that misdiagnosis or inappropriate treatment methods could occur. During the scripted video, the counselor and client said the following, regarding past mental health treatment, "Have you ever been in counseling before?" "No.

No I have not.” Participants reported no diagnosis as the most frequent and only theme for both clients.

5.9 Personal History

Next, participants were asked to identify the client history. Intake forms often times have an area for counselors to provide a report of the client’s history, which can include, but is not limited to, categories such as developmental history, education, occupation, relationship status, residence information, substance use, extracurricular interests, strengths, and weaknesses. Participants had unlimited space for their report of the client’s history. Themes are identified based on frequency with subcategorizing of maladaptive, adaptive, or neutral. The script included multiple discussion points that participants could address in the client history section of the intake form (see Appendix G for full script details). What is important to remember is that all participants heard the exact same script from the actors.

Participants identified maladaptive substance use (16) as the most frequent theme for the Euro-American. Participants also identified maladaptive substance use (12) as the most frequent theme for the Alaska Native. Two submissions that support the theme maladaptive substance use are “6 alcoholic drinks per week” and “drinking 3 sessions a week.” This means that while both the Euro-American and Alaska Native client has a theme of maladaptive substance use, the participants identify maladaptive substance use more frequently for the Euro-American. This means that while the Alaska Native had maladaptive substance

use assessed at the level of a presenting concern while the Euro-American did not, the Euro-American is identified to have more maladaptive substance use.

The second themes for the Euro-American are maladaptive sleep (5), maladaptive romantic relationship (5), and adaptive cooking (5), as these themes have the same number of frequency. The second theme for Alaska Native is maladaptive romantic relationship (7). This means that participants identified that the Euro-American client's history has equal presence of maladaptive sleep, maladaptive romantic relationship, and adaptive cooking. The Alaska Native, however, is identified to have a history of maladaptive romantic relationship that is supported more frequently than subsequent themes.

The third themes for the Euro-American are maladaptive occupational functioning (4) and maladaptive social functioning (4). The third theme for the Alaska Native is adaptive mother relationship (6). This means that the counselor trainees recognize the historical nature of the Alaska Native client's relationship with his mother to assist in his functioning. The Euro-American, however, has been identified to have a history that includes sub-optimal functioning in his occupational and social endeavors.

The fourth and final themes for the Euro-American are maladaptive father relationship (3) and adaptive mother relationship (3). The fourth theme for the Alaska Native is maladaptive brother relationship difficulties (5). This suggests that the counselors-in-training who viewed the Euro-American identify a history that includes the presence of a maladaptive relationship with his father, and an

adaptive relationship with his mother. The Alaska Native had the theme of adaptive mother relationship, as the second theme in his history. The counselors-in-training identify that a maladaptive relationship with the Alaska Native brother has been historically present. The Euro-American does not have a theme in his history section identifying a brother in either a maladaptive, adaptive, or neutral way.

The fifth theme for the Alaska Native, the Euro-American has no more identified themes, is the location of the client's neutral residence (4). Participants reported this theme by a text submission, such as "moved to Fairbanks 3 years ago." This means that the graduate students reported the Alaska Native's current residential location, with no value base associated with the residential location. The Euro-American did not have residence location identified as a theme in his history.

Maladaptive father relationship (3), maladaptive sleep (3), and maladaptive isolation (3) represent the sixth and final themes for the Alaska Native. Evidently, the counselor trainees viewing the Alaska Native identify the historical presence of a maladaptive relationship with his father, maladaptive sleep, and maladaptive isolation. The Euro-American had the theme maladaptive father relationship as the fourth theme, while the Alaska Native has maladaptive father relationship identified at the sixth level of themes. Maladaptive sleep was identified for the Euro-American as the second most frequent identified theme, in contrast to it being the sixth theme for the Alaska Native. The Euro-American had no themes

that supported maladaptive isolation, while the Alaska Native has an identified historical maladaptive isolation theme.

The Euro-American was identified as having an adaptive cooking theme. In the script, the client identifies he enjoys cooking and that it is his desired occupation. Counseling students identified the adaptive theme for the Euro-American, and not for the Alaska Native. Future research could focus its efforts in areas such as what methods of documentation best assist counselors-in-training to record and identify a client's history effectively?

Programs that train counselors may want to consider incorporating additional techniques that enable their graduate students to identify and document a client's history effectively. Counselors-in-training may benefit from discussions enabling them to process their values and beliefs in number of areas to potentially include differences in identifying either maladaptive or adaptive components, or specific details related to the personal history of clients.

Differences exist for the Euro-American and Alaska Native client. These differences could influence the counselor-in-training in a number of ways. The Euro- American will receive treatment that includes recognition of his adaptive cooking theme in his history. The client reported that cooking was his passion and ultimate goal. Treatment goals would likely address ways in which the Euro-American could begin the process of achieving his goal of cooking professionally. Participants did not identify that the Alaska Native had a cooking theme of any kind in his history. This will result in treatment that may not include efforts

towards manifesting the Alaska Natives desire to work as a chef.

Both the Euro-American and Alaska Native client had themes that identified relationships in his history, both adaptive and maladaptive. The Alaska Native has family members mentioned much more frequently than the Euro-American. This may be due to the emphasis on Alaska Native culture versus Euro-American culture. The Alaska Native has a brother identified in his history, which the script identifies he has, while the Euro- American has no brother mentioned in his history. This omission of a brother for the Euro-American is unfortunate as the counselors-in-training may find that discussions related to the client's brother could benefit the treatment process.

In conclusion, with all else being equal in the mock mental health videos, differences exist for the Euro-American and Alaska Native as related to identification of their personal history by participants. This difference can be seen not only by the difference of themes identified, but also within the frequency points of difference for the Euro-American and Alaska Native.

5.10 Family History

Participants were prompted to provide a report identifying the client family history. Intake forms have a section that prompts counselors to provide their clients family history to include, but not limited to, name, age, occupation, relationship, parental status, siblings, and extended family. Themes are identified in order from most to least mentioned themes; the themes are further categorized into maladaptive, adaptive, or neutral subcategories.

During the intake session, the counselor asks, “You mentioned your parents. Can you tell me about your family?” The client discusses his; father, mother, brother, aunt, grandma, and refers to extended family throughout the script. (Refer to Appendix G to review the entire script relating to the clients family history.)

Participants identified a maladaptive aunt mental illness (7) as the Euro-Americans most frequently identified theme. Participants identified adaptive mother relationship (13) as the most frequently identified theme for the Alaska Native. This means that when the graduate students were presented with the same script, they identified the most frequently present theme in the Euro-American client’s family history to be a maladaptive presence of an aunt with mental illness. The Alaska Native client’s most frequent theme is an adaptive relationship with his mother.

It is interesting to note that the first familial theme for the Alaska Native is a adaptive mother relationship while the last familial theme for the Euro-American is adaptive mother relationship. It appears that counselors-in-training initially focus on extended family relationships that are maladaptive for the Euro-American client. Conversely, counselor trainees identify, first, an adaptive mother relationship for the Alaska Native client. This may be in part due to Alaska Native being perceived as more family orientated while the Euro-American is perceived as more I orientated.

The second most frequently identified theme for the Euro-American is maladaptive father relationship difficulties (5). Likewise, the Alaska Native's second most frequently identified theme is also maladaptive father relationship (11). While both the Euro-American and Alaska Native have a maladaptive relationship with their father identified as the second theme in the client family history, the Alaska Native has twice as many text submissions supporting a maladaptive relationship with his father as the Euro- American client.

The third theme for the Euro-American is maladaptive romantic relationship difficulties (4). Maladaptive brother relationship (8) is the third most reported theme for the Alaska Native. The Euro-American is identified as having a family history that includes a maladaptive romantic relationship. The Alaska Native, however, has a family history that includes a maladaptive relationship with his brother.

Maladaptive social (3), neutral brother identification (3), and adaptive mother relationship (3) are the fourth and final themes, for the Euro-American. The fourth theme for the Alaska Native is maladaptive aunt mental illness (7). This means that the Euro- American, at the final level of themes, has an equal historical presence of maladaptive social experiences, a neutral relationship with his brother, and an adaptive relationship with his mother. The Euro-American has a neutral brother theme, while the Alaska Native had a maladaptive brother relationship theme as his third theme. The Alaska Natives fourth theme is maladaptive mental illness; although the frequency of this theme is fourth, the

Euro-American had maladaptive aunt mental illness as the first theme in his family history. However, both the Euro-American and Alaska Native had the same number of frequency of submissions that resulted in a theme of maladaptive aunt mental illness.

The fifth themes identified for the Alaska Native are neutral brother residence location (3) and maladaptive father traditional (3). The Euro-American had no themes identified at the fifth level. The Alaska Native client's family history was reported by participants to include neutral information related to where the clients brother resides, as well as a history of a maladaptive traditional father theme, illustrated by submissions such as "Father (John) is more like my brother, traditional," "I work hard, he thinks I am lazy," and "father is strict and traditional." The Euro-American client did not have any submission identifying a traditional theme, maladaptive, adaptive, or neutral. The Euro- American had no submissions identifying his brother's residence location.

Researchers may want to consider further exploration in the areas of effective counseling strategies to improve counselor-in-trainings retention of facts related to family history of their clients. Researchers could aim to discover, in future research, a format that aids graduate students in their skill sets related to memorizing or effectively documenting family history during the intake session. Know that in real world counseling, counselors must identify the information and create documentation all in one session; any information forgotten or omitted can lead to misunderstanding and misdiagnosis of the client.

Programs aiming to educate counseling graduate students may want to consider inclusion of training for identification of client's family history. While all participants identified a client history for the Euro-American and Alaska Native, their family histories vary. Participants' identified that the Alaska Native, had a maladaptive father traditional theme. Although the Euro-American spoke the same script, there was no traditional theme identified, illustrating that counselors-in-training may benefit from additional knowledge and practice with cultural values differing from their own. This experience could help students develop a sense of what tradition means to both the Euro-American and the Alaska Native cultures.

The clients experience a difference in themes within their reported family histories. The Alaska Native will have family discussed more often, as the counselors-in- training identify he is experiencing more maladaptive relationships than the Euro-American client. In fact, participants identify a maladaptive relationship with the Alaska Native's brother, while the Euro-American has a neutral theme for his brother. This will result in counselor trainees concluding that the Alaska Native has a relationship with his brother that does not function adaptively. Counselors often times utilize information gleaned from intake sessions, to facilitate topical areas to assist the client in improving their level of functioning. The Euro-American is less likely to have his counselors-in-training document a maladaptive component in his relationship with his brother; consequently, this may not be included in the treatment of the Euro-American.

Furthermore, the Alaska Native was identified as experiencing a maladaptive romantic relationship in his history. The Euro-American does not have a theme of romantic relationship, adaptive or maladaptive mentioned in his history at all. This translates to the inclusion of a history that includes a maladaptive relationship in the counselors-in-training conceptualization of the Alaska Native, and not for the Euro- American.

In conclusion, with all else being equal in the mock mental health videos, differences exist for the Euro-American and Alaska Native related to the identification of family history by participants. This difference can be seen not only in the difference of themes identified, but also within the frequency difference within themes for the Euro- American and Alaska Native client.

5.11 Physical Health

Participants were prompted to report on the client's physical health. Intake forms traditionally have an area that elicits counselors to identify the client's physical health, including, but not limited to diagnosis (if applicable), medications, and surgeries. Participants had unlimited space to write their assessment of the client's physical health.

During the mock mental health video, the counselor asks the client, "Do you have any physical concerns?" The client replies, "No not really, I used to work out but not in months now." (see Appendix G to review the full transcript of the physical health portion of the intake session).

Participants identified maladaptive tiredness or sleep (4) as the most frequent, and only, theme for the Euro-American. Participants identified adaptive physical health (4) as the most frequently mentioned theme for the Alaska Native. This indicates that the counselors-in-training viewed the Euro-American as experiencing maladaptive tired or sleep experiences. The Alaska Native, however, is identified to be adaptive physically, healthy. This means at the first level, the Euro-American and Alaska Native differ greatly in general physical functioning.

Maladaptive back pain (3) maladaptive substance use (3) and neutral pain medication (3) represent the second most frequently reported themes for the Alaska Native client. The Euro-American client had one theme identified for the physical health area of the intake form. This means that while the Euro-American had a maladaptive theme at the first level, the Alaska Native has a physical history that also includes maladaptive back pain and maladaptive substance use, neither of which are themes for the Euro-American. Additionally, the Alaska Native has a neutral pain medication theme, which was not mentioned as a theme for the Euro-American.

Future research may revolve around identifying scales that graduate students can utilize in order to identify types of physical health difficulties clients may experience, as well as rating system in order for the counselors-in-training to identify the degree of difficulty the physical health components are impacting the client. Researchers could aim to discover what, if any, differences exist in Euro-American versus Alaska Native reporting of physical health difficulties to mental

health providers. Counselor trainees could benefit from knowledge related to differences in reporting of physical difficulties across cultures and genders.

Programs endeavoring to develop graduate students who are able to effectively work with varying cultural populations may want to consider implementing strategies that enable students to acquire knowledge related to physical health. Counselors-in-training can improve their skills by continuing to practice asking questions that allow them to acquire, through the client's lens, their experience of physical health. Graduate students may benefit from additional knowledge surrounding cultural differences in assessment and reporting of physical health and pain. Counselor trainees should also be aware of their own predispositions related to identification of physical health functioning across cultures and genders. If counselors-in-training hold biases and assumptions that are impacting the difference in themes presented for the Euro-American and Alaska Native, those need to be identified and discussed during training programs and/or personal therapy to ensure that these biases do not impact future assessments of their clients.

Treatment may vary for the Euro-American and Alaska Native, as the themes identify different conceptualizations of these clients physical health, by the counselor trainees. The Euro-American, is identified to be experiencing one physical health difficulty: he is tired and is experiencing low energy. Treatment may include components that attempt to assist the Euro-American to improve his functioning related to his lack of energy and experience of being tired. The Euro-

American did not have back pain identified by counselors-in-training. During the mock mental health session, the client identifies he has back pain from an accident and that he takes pain medication one to two times a week to manage his pain symptoms. The Euro-American will receive no other efforts during his treatment regarding his back pain, despite him reporting his pain and medication use for his back pain.

The Alaska Native client's treatment may be very different than the Euro-American client. The Alaska Native's treatment will include an emphasis on an overall adaptive physical health experience, but may also include treatment efforts that either; validate the experience of pain or attempt to facilitate more optimal functioning in the areas of maladaptive back pain, maladaptive substance use, and neutral pain medication use.

In conclusion, with all else being equal in the mock mental health videos, participants detected differences related to physical health between the Euro-American and Alaska Native. This difference can be seen in the physical health themes identified for the Euro-American, versus the Alaska Native.

5.12 DSM Multi-Axial Diagnosis

According to the DSM-IV-TR (APA, 2000), the multi axial system enables the counselor to assess their clients over multiple domains. The domains are represented over five axis: "Axis I, clinical disorders and other conditions that may be a focus of clinical attention; Axis II, personality disorders and mental retardation; Axis III, general medical conditions; Axis IV, psychosocial and

environmental problems; and Axis V, global assessment functioning” (APA, 2000, p. 9).

5.13 AXIS I

As stated in the DSM-IV-TR (2000), Axis I is the axis for providers to identify all disorders or areas of clinical focus that are not personality disorders or mental retardation disorders, as those are reported on Axis II, of the multi axial diagnosis system. If providers identify a client has multiple disorders present on Axis I, they are to list the diagnosis in descending order, beginning with the main or principal diagnosis first, and so on. The DSM-IV-TR (APA, 2000) identifies 16 disorders that are included in Axis I: disorders usually first diagnosed in infancy, childhood, or adolescence; delirium, dementia, amnestic, and other cognitive disorders; mental disorder due to a general medical condition; substance-related disorder; schizophrenia and other psychotic disorder; mood disorders; anxiety disorders; somatoform disorders; factitious disorders; dissociative disorders; sexual and gender identity disorders; eating disorders; sleep disorders; impulse-control disorders; adjustment disorders; and other conditions that may be of clinical attention (APA, 2000). (See Appendix G to review the script utilized throughout the mock mental health videos as counselors-in-training utilize all information gleaned from the session to diagnosis Axis I.)

Of the participants who viewed the Euro-American intake session, 80% identified at least one diagnosis on Axis I. Of the participants who viewed the Alaska Native, 80% diagnosed him with at least one diagnosis on Axis I. This

means that regardless of difference, both clients were diagnosed with one diagnosis.

Of the diagnosis provided for the Euro-American, 37.5% reported a diagnosis of Major Depressive Disorder, see Appendix I to review diagnostic criteria for Major Depressive Disorder. Twenty-five percent of the diagnoses were Social Phobia, see Appendix J for diagnostic criteria. Twenty five percent of the diagnoses identified were Insomnia, review Appendix K for diagnostic criteria. Twelve point five percent of the diagnosis identified was Mood Disorder Substance Induced, with depressive features, mild, see Appendix L for diagnostic criteria.

Of the diagnosis reported for the Alaska Native, 33.33% were Major Depressive Disorder, review Appendix I for diagnostic criteria. Thirty-three point thirty three percent of the diagnoses were Adjustment Disorder, see Appendix M for diagnostic criteria. Eleven point eleven percent of the diagnoses were specific phobia, see Appendix N for diagnostic criteria. Eleven point eleven percent of the diagnosis was insomnia, see Appendix K for diagnostic criteria. Lastly, 11.11% of the diagnosis was alcohol abuse, see Appendix O for diagnostic criteria.

Researchers may want to direct efforts toward improving graduate students awareness and execution of the cultural formulation set forth in the DSM-IV-TR (APA, 2000). Counselors-in-training identify differences of diagnosis based on the differences in presentation of the Euro-American and Alaska Native in this research. These results can assist in identification of stereotypes and biased beliefs

that counselors-in-training experience, consciously or unconsciously, towards Euro-Americans and Alaska Natives. Researchers may want to consider the development of tools that can enable counselors to develop their personal awareness and their awareness of other cultures.

Counselor trainees may benefit from additional emphasis related to skills that enable them to accurately identify symptoms, and to identify if those symptoms meet the criteria set forth in the DSM-IV-TR (APA, 2000). Counselors-in-training can additionally benefit from exploring their personal values and beliefs about Euro-Americans, as well as Alaska Natives. The diagnosis differences are noteworthy at the Axis I level of the diagnosing system for both the Euro-American and Alaska Native. Counselors-in-training needs to grapple with their own belief systems and how those impact the diagnosis they prescribe to their clients, regardless of ethnicity.

Additionally, training programs may want to consider additional emphasis on diagnosing in general for their students. The participants in the current study identified general disorders they prescribed to their client, however the majority of participants did not identify diagnostic codes, subtypes or severity and course specifiers utilized in the DSM- IV-TR. Diagnostic codes are the numeric codes identified in the DSM-IV-TR (APA, 2000). Two examples of Diagnostic codes are 296.2x Major Depressive Disorder, single episode versus 296.3x Major Depressive Disorder, Recurrent. Subtypes and course specifiers accompany the majority of diagnosis in the DSM-IV-TR (APA, 2000). Examples of subtypes and

course specifiers are: chronic, mild, moderate, late onset, or with melancholic features. These specifiers enable counselors to note the details of the diagnosis so that the diagnosis most accurately represents the client's mental state (p. 1).

This means that although both the Euro-American and the Alaska Native may get, on average, the same number of diagnosis on Axis I, it appears that the type of diagnosis vary. The Euro-American may be diagnosed and subsequently treated across one or more of the following diagnoses: Major Depressive Disorder, Social Phobia, Insomnia, and Mood Disorder, Substance Induced, with depressive features, mild. The Alaska Native, however, may be diagnosed and treated on Axis I for one or more of the following disorders; Major Depressive Disorder, Adjustment Disorder, Specific Phobia, Insomnia, or alcohol abuse. While one of the diagnosis, Major Depressive Disorder, is the most identified and similar diagnosis for both the Euro-American and Alaska Native, the subsequent diagnoses vary greatly.

The Euro-American will be treated for a social phobia, while the Alaska Native will be treated for an adjustment disorder. Participants in this study did not identify subtype or specifier for this disorder. Therefore the specific type of adjustment disorder was not gleaned from the submissions. Next, the Euro-American will be treated for insomnia, while the Alaska Native will be treated for a specific phobia. Finally, the Euro-American will be treated for mood disorder--substance induced with mild depressive features--while the Alaska Native will be treated for insomnia. Lastly, the Alaska Native will be treated for alcohol abuse,

while the Euro-American will not receive treatment related to alcohol abuse.

This means that with all else being equal, the Euro-American and Alaska Native were not diagnosed with the same diagnosis on Axis I. This can be seen by the varying diagnosis the Euro-American receives, versus the diagnosis range that the Alaska Native receives.

5.14 AXIS II

According to the DSM-IV-TR (APA, 2000), Axis II is the axis in which providers are able to identify diagnosis related to either personality disorders or mental retardation disorders. Counselors are to identify if a diagnosis is present on Axis II, as well as report if the Axis II diagnosis is the main diagnosis or main reason for coming to therapy. There are twelve disorders in Axis II in the DSM-IV-TR: paranoid personality disorder, schizoid personality disorder, schizotypal personality disorder, antisocial personality disorder, borderline personality disorder, histrionic personality disorder, narcissistic personality disorder, avoidant personality disorder, dependent personality disorder, obsessive-compulsive personality disorder, and mental retardation (APA, 2000). (Refer to Appendix G for the full script spoken during the mock intake session.)

Of the participants who viewed the Euro-American mental health intake, 100% of the participants identified no diagnosis on Axis II. Of the participants who viewed the Alaska Native intake video session, 100% of the participants identified no diagnosis. Regardless of differences, neither client was identified to have a diagnosis on Axis II.

Researchers may consider researching effective ways for counselors-in-training to be exposed to an array of cultural populations who are currently diagnosed with personality disorders or mental retardation. This line of research could benefit students in understanding cultural variation in presentation and meaning of abnormal personality symptoms across cultures. If researchers could develop an immersion training program where counselors-in-training get either face to face exposure or video exposure to varying cultural populations they may otherwise not be exposed to it could further benefit their diagnostic knowledge and skills on Axis II.

Assessment and treatment did not vary for the Euro-American or Alaska Native client on Axis II. Counselors-in-training will not spend treatment time focusing on personality disorders or mental retardation during treatment. This will result in both the Euro-American and Alaska Native working during treatment time on the diagnosis, though those vary, identified on Axis I.

5.15 AXIS III

Of the multi axial diagnosis system in the DSM-IV-TR (APA, 2000), Axis III is the area for providers to identify their client's general medical conditions. According to the DSM-IV-TR (2000), providers are to identify any historical or current medical conditions the client has experienced. There are 16 diagnosis identified in the DSM-IV-TR:

infectious and parasitic diseases, neoplasm's, endocrine,
nutritional and metabolic diseases and immunity disorders,

disease of the blood and blood forming organs, disease of the nervous system, disease of the circulatory system, disease of the respiratory system, disease of the digestive track, disease of the genitourinary system, complication of pregnancy, childbirth, and the puerperium, disease of the skin and subcutaneous system, disease of the musculoskeletal system and connective tissue, congenital anomalies, certain conditions originating in the perinatal period, symptoms, signs, and ill-defined conditions, and injury and poisoning. (APA, 2000, p. 30)

During the mock mental health video, the client reports back pain from an accident he had many years ago. The client discloses that he takes pain medication one- to-two times per week, as needed, to manage his back pain. The script included no other information related to physical health other than the client identifies he does not exercise as much as he previously had. (See Appendix G for further detail of the script relating to the physical health of the client.)

Twenty percent of participants who viewed the Euro-American client intake session reported a diagnosis of back pain on Axis III.

Fifty-seven percent of participants who viewed the Alaska Native identified a diagnosis on Axis III. Of the diagnosis identified for Axis III, 75% reported a back injury, while 25% reported a diagnosis of insomnia.

Researchers may consider efforts related to developing a method to assist counselors-in-training to accurately identify physical health components and document them effectively, regardless of a client's culture. Training programs may want to include courses such as biological bases of behavior, or Health Psychology in order to solidify concepts related to physical health. As counselors-in-training develop their skills, it may prove useful to provide them with a scale(s) to identify severity of physical pain as reported by their clients.

It seems fair to suggest that since there is varying identification of physical health for both the Euro-American and Alaska Native, perhaps graduate students could benefit from exploring their beliefs related to physical functioning and how those may be similar or different than those of other cultural populations. As identified earlier, counselors-in-training may also benefit from exploring their personal values that influence their diagnosis related to physical health of their clients.

This means that although the counselors-in-training were exposed to the same script in the video, one of participants who viewed the Euro-American client identified a diagnosis on Axis III, while 57% of participants who viewed the Alaska Native client identified a diagnosis on Axis III. This means that when the counselor trainees were presented with the same stimuli, the Alaska Native has more than double diagnosis on Axis III identified. The Alaska Native client's treatment is much more likely to include components related to improving his physical functioning.

Furthermore, of the 20% of counselors who provided a diagnosis on Axis III for the Euro-American client, 100% identified back pain. The Alaska Native, however, was diagnosed by 57% of participants. Of the diagnosis identified for the Alaska Native client, 75% were back pain and 25% insomnia. Ultimately, the Euro-American will have minimal identification of his back pain, resulting in less treatment time focusing on his back pain experience. The counselors-in-training identified that the Alaska Native experiences back pain more frequently than the Euro-American, so he may experience more treatment efforts toward improving his physical health functioning. Treatment may additionally focus on insomnia difficulties that the Alaska Native is identified as experiencing on Axis III, while the Euro-American will not have treatment time spent on insomnia difficulties, as they were not identified on Axis III.

All else being equal, the Euro-American and Alaska Native have both a difference in the amount of diagnosis, as well as variation of type of diagnosis present on Axis III. The Euro-American and Alaska Native client may not be treated in the same way by graduate students, based on the variation of diagnosis and variation of types of diagnosis present on Axis III.

5.16 AXIS IV

The DSM-IV-TR (APA, 2000) reports that Axis IV is the axis for counselors to report their client's psychosocial and environmental problems. This axis is the area where, according to the DSM-IV-TR, counselors identify problems such as, but are not limited to, primary support (e.g., death or divorce);

social environment (e.g., retirement or death of friend); educational (e.g., illiterate or difficulties with teachers); occupational (e.g., unemployment, difficulties with boss); housing (e.g., homeless or lack of money); economic (e.g., poverty or welfare support difficulties); access to health care services (lack of transportation or no health insurance); interaction with legal system/crime (e.g., arrest or charges); and other psychosocial or environmental problems (e.g., disasters or war) (APA, 2000). During the mock mental health video, the client and counselor discussed a few topics such as the recent break-up with a girlfriend and difficulty related to residential status. (See Appendix G for the full script, spoken during the videos.)

Of the participants who viewed the Euro-American intake video, 80% of the participants provided a description of psychosocial and/or environmental problems. Of those participants who viewed the Alaska Native intake video, 71.42% of the participants identified psychosocial and/or environmental problems.

Of the psychosocial and/or environmental problems identified for the Euro-American, 33.33% were maladaptive occupational, 20% were maladaptive social, 13.33% maladaptive romantic relationship, 13.33% maladaptive financial, 13.33% maladaptive residence, and 6.67% maladaptive primary support.

Of those participants who identified psychosocial and/or environmental problems for the Alaska Native, 27.27% were maladaptive social, 18.18% maladaptive occupational, 18.18% maladaptive financial, 18.18% maladaptive

primary support, 9.09% maladaptive romantic relationship, and 9.09% maladaptive depressed mood. It is interesting to note that the Alaska Native client has the inclusion of maladaptive mood despite axis IV is intended for psychosocial and environmental problems. It seems that counselor trainees may identify that the Alaska Natives mood is impacting his functioning on axis IV.

Researchers may want to discover what belief system(s) counselors-in-training have that result in the Euro-American experiencing maladaptive occupational functioning more than the Alaska Native. Research such as this could begin to identify a core value(s) that influence the diagnosis of Euro-American, versus Alaska Native clients.

Programs may want to consider additional class time discussions on topics such as mood across cultures, family values across cultures, cultural values, knowing oneself, and knowing another. In depth discussions that enable graduate students to explore the similarities and differences in these topical areas across cultures may assist them in their execution of diagnosis on Axis IV.

Furthermore, training programs way want to spend additional time discussing axis IV. Discussions could revolve around such topics as (1) key concepts that clients verbalize to indicate possible maladaptive features in their psychosocial or environmental experience, and (2) discuss how to gauge the severity of maladaptive components effectively and accurately along a cross-cultural spectrum.

Treatment for the Euro-American and Alaska Native may vary on Axis IV. The assessment for the Euro-American includes identification of psychosocial and environmental concerns that vary in kind and frequency from the Alaska Native clients psychosocial and environmental concerns. There is some overlap: some themes are mentioned for both the Euro-American and Alaska Native, but these themes are identified in different order. Both the Euro-American and Alaska Native have a concern identified that the other does not.

The Euro-American may experience treatment efforts aimed at improving his functioning in the following maladaptive areas: occupational, social, romantic relationship, financial, residence, and primary support. The DSM-IV-TR identifies that a diagnosis on any axis is to be addressed in order of what is identified to be the first or most maladaptive difficulty identified (APA, 2000). For the Euro-American, treatment may begin with assisting him with his maladaptive occupational functioning; the client identified cooking to be his passion and goal in his career. Next, the other maladaptive themes may be addressed in descending order during the treatment process. The Euro-American may experience treatment related to his maladaptive experience of his residential status. The client reports in the script that he thinks some of his problems are because he is living with his parents. The Alaska Native client may not receive treatment related to his residential status.

The Alaska Native will likely experience his Axis IV treatment differently than the Euro-American client. The Alaska Native may have treatment efforts

toward improving his functioning over the following maladaptive areas: social, occupational, financial, primary support, romantic relationship, and depressed mood. The Alaska Native has the concern identified depressed mood, whereas the Euro-American has not. Consequently, the Alaska Native client may experience treatment efforts related to his maladaptive depressed mood.

This means that all else being equal the Euro-American and Alaska Native, have both a difference in amount of diagnosis as well as variation of type of diagnosis present on Axis IV. The Euro-American and Alaska Native client may not be treated in the same way by counselors-in-training, based on the variation of diagnosis and variation of types of diagnosis present on Axis IV. Students must aim to be aware of all things in the counseling relationship, in order to be effective.

5.17 AXIS V (Global Assessment of Functioning Score)

As described by the DSM-IV-TR (APA, 2000), the GAF score on Axis V is a range from 1-100 that identifies the clients overall level of functioning. The GAF utilizes 10 point cut offs to divide the categories of functioning for the GAF score (see Appendix P). At the highest point of the GAF scale, 100, the client would be experiencing superior functioning in all areas, while the 1 point GAF score would indicate the client is in consistent danger for suicidal or homicidal behaviors and thoughts. The DSM-IV-TR (APA, 2000) further asserts that the client's physical limitations and environmental limitations should not be taken into account when assessing the GAF score (APA, 2000). Providers utilize the

entire intake session to determine the current GAF score of their clients. (See Appendix G to review full script of mock intake session.)

Eighty percent of participants who viewed the Euro-American intake video provided a GAF score. Of those participants who viewed the Alaska Native video, 71.42% of the participants identified a GAF score. A t test was done resulting in a statistical difference of $p < .05$. This means that all else being equal, the differences caused a statistical difference of mean GAF scores for the Euro-American versus the Alaska Native client.

Researchers may want to consider exploring alternative ways that counselors-in-training can understand the GAF assessment tool. Perhaps students could benefit from not only written explanations of the GAF ranges, but videos to support behaviors and verbalizations that could aid in their understanding of overall functioning in clients. Additionally, researchers may want to explore the values and beliefs that guide counselors-in-training to view the Euro-American as overall functioning higher than the Alaska Native client who delivered the exact same life story.

Counselor trainees could benefit from additional training related to clients with varying cultures. Focus could be placed on language patterns, mood, behavior patterns, elders, values, and beliefs of people(s) of varying cultures. Exposure to other cultures can assist counselors-in-training in understanding the varying presentations that people from other cultures can display or verbalize.

Additionally, training programs may want to include additional assignments or practice experiences that assist students in developing their ability to diagnosis effectively and accurately across cultures. Currently, the counselors-in-training have supported that the clients are clinically different in their overall level of functioning, with all else being equal; these counseling students could benefit from class time exploration of what values and beliefs they posses that influenced the difference in assessment for the Euro-American and Alaska Native client.

The GAF score, again, identifies the counselor trainees overall assessment of the clients level of functioning. The counselor-in-training is supposed to take into consideration the entirety of the first intake session to determine an accurate GAF score. These results support that the Euro-American and Alaska Native client may experience very different treatment based on their GAF score results.

The Euro-American, with the mean score of 65.5, would fall in to the following GAF score category: “Some mild symptoms (e.g., depressed mood and mild insomnia) or some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships” (APA, 2000, p. 34).

The Alaska Native client, with the mean GAF sore of 54.2, would fall in to the following GAF score category: “Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) or moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflict with peers or co-workers)” (APA, 2000, p. 34).

This means that with all else being equal, the Alaska Native is identified as having moderate symptoms, while the Euro-American is identified as experiencing some mild symptoms. Furthermore, the Alaska Native is 4.2 points above a 50 GAF score, which according to the DSM-IV-TR (APA, 2000) identifies a diagnosis of Severely Emotionally Disturbed, while the Euro-American is 15.5 points away from the Severely Emotionally disturbed GAF score.

5.18 Summary

Cultural diversity is at the forefront of our ever-changing population. According to Pomerantz (2008), over the last 20 years, minority ethnicities have increased in minority ethnic size as well as proportionally to the overall population. Pomerantz notes that the Latino/Latina/Hispanic population and the American/Pacific Islander population has increased in size by 50%. Furthermore, 28 million first generation immigrants were reported residing in the United States in 2000 (Pomerantz). The translation is that counselors-in-training who are currently enrolled in graduate programs have an increased likelihood to provide counseling services to multi ethnic populations, who may at times differ from their own ethnicity.

The purpose of this dissertation research was to answer whether graduate counseling students in training who were given identical client information, history, and presenting issues, but a variation in ethnicity, persistently display the tendency to view an Alaska Native as less adaptive than a Euro-American? And if

so, how does this difference manifest itself?

The quantitative hypothesis was that, with *all* else being equal, counseling students would view an Alaska Native client as more maladaptive than a Euro-American client. It was hypothesized that counselors-in-training would express this tendency through more frequent diagnosis, more extreme diagnoses, or lower GAF scores.

The results supported the quantitative hypothesis: counselor trainees diagnosed the Alaska Native as expressing more overall maladaptive functioning than the Euro-American client. There were 19 items on the mental health intake form used in the present study; three were demographic questions, 11 were written assessment questions, and the final five items were the multi-axial diagnostic system in the DSM-IV-TR (APA, 2000).

The first three items on the intake form sought demographic information about the client: name, date of birth, and gender. The results of the demographic information for the Euro-American and Alaska Native have two items that differ, and one area with the same results. The results identify that all participants were able to accurately identify the gender of both clients. Participants were able to identify the Euro-American Jerry Caruk's full name more frequently, and more accurately, than counselors-in-training were able to identify the Alaska Native Jerry Caruk's full name. All participants who viewed the Euro-American were able to report his date of birth, accurately; counselors-in-training were much less accurate (57.14%) when reporting the Alaska Natives, date of birth. With all else

being equal, counselors-in-training did not identify demographic information similarly for the Euro-American and Alaska Native. Participants are more effective at identifying the Euro-Americans, demographic information than the Alaska Natives demographic information.

The next six items on the intake form are the written assessment areas, which include MSE, presenting concerns, history of mental health treatment, personal history, family history, and physical health. The results identify that on four of the six items—M.S.E., client history, physical health and presenting concerns--the Euro-American is assessed as more adaptive than the Alaska Native. For the remaining two items--history of mental health treatment and family history--both the Euro-American and Alaska Native are assessed as having the same amount of maladaptive and adaptive themes identified. With all else being equal, counselors-in-training do not assess the Euro- American and Alaska Native as functioning the same on the written portion of the intake form. Overall, participants identify the Euro-American is functioning more effectively than the Alaska Native on the written portion of the intake form.

The remaining five items are the multi-axial diagnostic system set forth by the DSM-IV-TR (APA, 2000) includes Axis I thru V (GAF score). Eighty percent of participants identified a diagnosis on Axis I for the clients. However, there is variation in type of diagnosis on Axis I for the Euro-American and Alaska Native client. Participants identified the same--no diagnosis--on Axis II for both clients. Fifty-seven point fourteen percent of participants diagnosed the Alaska Native on

Axis III, while 20% of participants diagnosed the Euro-American. 80% of participants diagnosed the Euro- American, while 71.42% diagnosed the Alaska Native on Axis IV. The final axis of the multi-axial system is the GAF score. On Axis V, the Euro-American was diagnosed as being more optimally functioning overall compared to Alaska Native. With all else being equal, counselors-in-training do not assess the Euro-American and Alaska Native as functioning the same on the multi axial portion of the intake form. Overall, participants identify the Euro-American as functioning more adaptively than the Alaska Native on the multi axial portion of the intake form.

These results identify graduate students who have already facilitated 50-350 face- to-face client hours in their graduate programs and diagnose an Alaska Native as more maladaptive than a Euro-American client when presented with the same script and environmental stimuli. This identifies that for counselors-in-training, identification of Euro-American, results in more adaptive functioning diagnosis than the Alaska Native.

The Euro-American may be experiencing what McIntosh (2002) explains to be white-privilege. As previously identified, “White privilege is defined as the unearned advantages and benefits that accrue to white people by virtue of a system normed on the experiences, values, and perceptions of their group” (2002, p. 1). The Euro-American may be unaware of his white privilege in this setting, but results support that participants diagnosed him as more optimally functioning than the Alaska Native. This does not necessarily mean that the Euro-American

clients diagnosis is accurate; if counselors-in-training see the Euro-American more favorably because he is Euro-American, his diagnosis may be at a higher level of functioning than he is authentically experiencing. Sue (2003) explains: “Whiteness is transparent precisely because of its everyday occurrence, it represents institutional normality, white people are taught to think of their lives as morally neutral, average, and ideal” (2003, p. 764). Counselor trainees supported this by diagnosing the Euro-American as being more optimally functioning than the Alaska Native.

The purpose of this research was to see if a difference existed diagnostically for the Euro-American and Alaska Native client. Since multiple differences do exist diagnostically, counselors-in-training should attempt to explore their personal values, including stereotypes. Stereotypes, in the words of Baron, Byrne and Branscombe are “beliefs about a social groups in terms of the traits or characteristics that they are deemed to share” (2006, p. 213). If the graduate students value systems include stereotypes about Euro-Americans and/or Alaska Natives, diagnosis may not accurately reflect their client’s current mental health state.

Again, as identified in chapter two of this text, a review of the literature present for Alaska Native populations identifies that the research topic of substances and alcohol are discussed more than many other topical areas. If students are aware of this literature the skewed representation in research of Alaska Native people(s) may have influenced the beliefs counselors-in-training

identify when they cognitively process Alaska Native people(s). This body of research may have impacted the counselors-in-training assessment of the Alaska Native, as he was diagnosed overall more frequently, but with more frequent diagnosis of substance related disorders, as well.

If this belief continues, and the counselor trainees eventually become counselors, their work with Alaska Native clients, may include prejudice and stereotypes, based on perceptions of their culture. This will impact the Alaska Natives and Euro-Americans diagnosis, overall functioning, and course of treatment. Additionally, if these beliefs continue, counselors-in-training will continue to assess their Euro-American clients as more optimally functioning than they may in fact be.

The counselor trainees may have already possessed personal schemas that include stereotypes or prejudices when they began their academic endeavors. As explained earlier in this text, prejudice is “the affective component, or the feelings, we have about particular groups” (Baron et al., 2006). If counselor trainees believe that many or all Alaska Native people(s) use substances and alcohol, they have adhered to an inaccurate belief system.

In order to address the difference in diagnosis for the Euro-American and Alaska Native, counseling graduate students must examine what belief systems activate when they identify or experience a Euro-American or Alaska Native. This research supports that what counselors-in-training visually experience impacts their diagnosis and assessment of these clients.

Counselors-in-training are taught in courses to pay attention to body language and physical appearance, as these components can provide useful information. While some assessment items were similar for the Euro-American and Alaska Native, i.e., gender identification and no Axis II diagnosis, it appears that visual, behavioral, and language pattern differences influence how these graduate students *knew* and *understood* their clients.

As discussed in chapter three, cross-cultural populations embody varying physical appearance, body movements, and language patterns. Misunderstanding or bias regarding values and/or assumptions about personal appearance, behaviors, and language patterns of clients, on the part of the counselors-in-training, increases diagnosis differences for their clients.

Students identified to possess stereotypes or prejudices in their value system must be guided to not only stop working with clients and to address those beliefs, be willing to reexamine those belief systems, and either (a) honestly alter their belief systems or (b) willingly depart from the counseling program they currently are housed in. If training programs do not work with counselors-in-training, clients may endure unethical and culturally incompetent diagnosis and treatment.

Dana (1998) asserts that the DSM-IV-TR does not include enough information for providers to diagnosis, assess, and treat multi cultural populations. Feisthamel and Schwartz (2009) identify that minimal research has been conducted regarding impact of race on diagnosis and how race impacts onset, symptoms, course, diagnosis, and treatment. The DSM-IV-TR has made additions

that reflect recognition that culture must be considered, including subsections that specifically address culture, gender, and age; a cultural formulation outline; and a list of culture bound syndromes (APA, 2000). Hence, this research supports that, with all else being equal, counseling students do view an Alaska Native client as more maladaptive than a Euro-American client. The participants proved this by identifying more frequent diagnosis and lower GAF scores for the Alaska Native.

The possible solutions to this phenomenon are many, and each solution is complicated and timely at best. However, counseling graduate students and counselor training programs must address the difference in diagnosis for the Euro-American and Alaska Native client on a few different levels. The first level is the counselor-in-training; second level is the faculty within the graduate program and the graduate program curriculum itself; the third level is the research level; and ultimately concluding with the community and societal level. At the first level, graduate students must develop an honest understanding of their cultural self and the values within their own culture. Students may need to endeavor in an in depth process that enables them to not only identify their values but to explore how and why they maintain these values. Enabling counselor trainees to process their beliefs and knowledge about themselves, in class or personal therapy, may assist them in identification of personal values they possess.

Not only do counseling students have to honestly and effectively be able to identify their cultural self and the values they hold within that cultural framework, they must be able identify where their biases lay within that cultural framework.

All people have biases; it is virtually impossible to not. However, there are wide scopes of concepts one can be biased about and a wide range of degree of bias one can have within that bias. What seems important in the process of becoming a culturally competent counselor is not only knowing oneself, but accurately identifying and owning ones biases and processing how those biases, if gone unchecked, will impact the course of mental health treatment for clients.

Those counselors-in-training, or counselor training programs, whom identify a graduate student who adheres to values that include prejudice, bias, or stereotypes towards others must take action immediately. At the very least, an academic treatment plan of sorts may need to be implemented so that the counselor-in-training can address their prejudice, bias, or stereotypes and begin the process of addressing those belief systems. It is good for counselor trainees to recognize similarities and differences in other cultures, but they cannot diagnose the natural differences as maladaptive.

Counselor trainees who refuse to process or develop a non-judgmental approach towards those who differ would be violating APA and ACA ethical codes, and therefore must stop, at the very least pause, their active pursuit of becoming a counselor. It is important to reiterate that while most people in society do not have to operate under a non judgmental approach towards people(s) counselors-in-training must. Faculty should consider additional monitoring of those students who have historically adhered to judgmental values systems until they are certain their values are not influencing the clients they serve. Graduate

programs may want to consider requiring students to complete personal therapy, during their program, so they have a confidential setting to explore their values.

At the second level, training programs, certainly ones located in Alaska, may want to consider the results of this research. There may be a number of solutions or strategies counseling programs may want to consider to either develop or adapt their current programs. Perhaps faculty may want to further collectively process the topic of culture and all that it embodies. This type of discussion could include personal culture identification, current teaching strategies implemented, useful articles/texts/videos related to culture, and ways the faculty can further assist their students in their cultural awareness.

Perhaps if faculty housed in counseling programs process as a collective their strategy or strategies for presenting culture to students they may be able to assist one another in doing so. If not already in place, programs may want to consider adapting or developing components of their programs, to include additional discussion on culture. Possible options for programs to consider are discussions and papers related to: cultural self and values within the counselor-in-trainings cultural worldview, cultural awareness of a multitude of cultures, to include emphasis on the multi cultural populations residing in at least, the same state, Alaska in this case. These types of discussion or papers could assist in conveying what the range of normal or expected visual, language and behavioral components are within culture specific populations. It may be helpful for faculty to verbally express to students the natural differences that occur in cultural

populations, and present them as normal and adaptive, for that culture.

This could include discussions that identify, for example, that more frequent eye contact is normal for many Euro-Americans, and less eye contact is normal for many Alaska Natives. Another example is if an Alaska Native male identifies his culture believes killing a seal will make him a man, then that is true and normal for that Alaska Native male within his cultural values. This means that if a Euro-American male believes he must turn 18 to be a man, then it is true and normal for that Euro-American male that he is a man when he is chronologically 18 years old. This concept of what is normal or healthy for cultural people extends across all areas embodied in the cultural self, to possibly include, but not limited to gender norms/values, religion/spirituality, norms/values, tradition norms/values, language norms/values, behavior norms/values, physical norms/values, clothing norms/values, social norms/values, art norms/values, symbol system norms/values, education norms/values, and developmental experience processes norm/values. These types of discussions may aid counselor trainees in their knowledge base of cultural peoples, which may assist in effective diagnosis and treatment of their clients.

Another solution that graduate counselor training programs may want to consider is a cultural immersion concept. A cultural immersive experience could include for students is a number of events/experiences resulting in the counselor trainees being immersed in a various cultures. In Alaska this could include exposure to Alaska Native people(s). Exposure could include, but is not limited to

conversations with Alaska Native individuals participation in Alaska Native culture, i.e., eating traditional foods, learning traditional dance, and/or attending cultural events, such as the Festival of Native Arts (FNA). Sheer exposure to cultures can enable counselors-in-training to visually experience points of similarities and difference that occur normally and naturally for that cultural population.

At the third level researchers represent a part of the solution process. As previously discussed, there are many research options that can be developed in the future. Researchers interested in culture may want to extend the body of knowledge that is available related to Euro-American and Alaska Native people(s) culture. In this research, it seems that the points of difference in the Euro-American and Alaska Native presentation are enough to impact the way participants assessed the Euro-American and Alaska Native.

In general, research must be conducted in the United States, and globally, to determine if differences exist in diagnosis, diagnosis extremity, or GAF scores for the multitude of diverse cultural populations present on the planet Earth. Researchers must know if and how this difference in diagnosis persists for other cultural groups. Certainly, it seems essential to determine if counselors-in-training housed in counseling programs have consistent diagnostic differences with the majority and minority populations they come into contact with in their clientele population.

Furthermore, it seems pertinent to support that it may be important to research if differences in diagnosis exist for counselors who have already graduated and are practicing counselors with their cultural clients. Once researchers understand to what type and degree differential diagnosis is occurring for varying cultural populations, they may want to identify how to educate or address those diagnostic differences in order to facilitate equal assessment and treatment across cultures, majority or minority. This could include, but is not limited to, any research that further identifies any components of Alaska Native people(s) culture and Euro-American culture that can assist counselors-in-training's knowledge base.

The final level that can assist in solving, in part, the differences in diagnosis for the Euro-American and Alaska Native client, are at the community and societal level. Communities must make their values apparent to the whole. If a community fosters value systems that include doing no harm to others, or identify the value that all people(s) are equal, then the behaviors towards and depiction of those people(s) must be congruent with the values set forth.

In the United States all people should be treated equal; the Euro-American and Alaska Native are not treated equal. One solution is to look and examine the community and society to determine how the community and society regard, or depict, Euro- American and Alaska Native people(s). If one identifies that an inequality exists, one must take the responsibility to use their voice or behaviors to stop unfair regard or depictions of cultural people(s).

Since diagnostic and functioning differences exist for the Euro-American and Alaska Native, it is recommended that counselors-in-training and faculty in counselor training programs--and ideally communities and society in its totality--examine their role in the differential assessment of the Euro-American and Alaska Native client received. Taking responsibility of the values, bias or prejudice one adheres to is important. Ensuring that those values do not impede the counseling process is paramount. Neither Euro-American nor the Alaska Native client deserves to be assessed as more or less adaptive or maladaptive than the other. However, that is what occurred. Jerry, the client in this research, and all Jerrys in the world, deserve to be effectively seen and heard through their unique cultural lens. Failure to do so results in an increased likelihood that counselors-in-training will assess a Euro-American and an Alaska Native client, differently, in a multitude of ways. In this particular research, this phenomenon is reflected by the relative difference on emphasis of diagnosis, and overall identified level of functioning for the Euro-American and Alaska Native Jerry.

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APPENDIX A:
INSTITUTIONAL REVIEW BOARD PROTOCOL APPROVAL

Please note that University of Alaska Fairbanks IRB has taken the following action on IRBNet:

Project Title: [170917-2] Differences between frequency of diagnosis, diagnosis extremity, and GAF score in Euro American and Alaska Native clients
Principal Investigator: Allan Morotti, PhD

Submission Type: New Project
Date Submitted: September 28, 2010

Action: EXEMPT
Effective Date: September 30, 2010
Review Type: Exempt Review

Should you have any questions you may contact Bridget Watson at fyori@uaf.edu.

Thank you,
The IRBNet Support Team

www.irbnet.org

APPENDIX B:

UAF Email to Instructors

My name is Britton Niles. I am an Interdisciplinary Doctoral Candidate in the School of Education, studying multicultural counseling and psychology. I am conducting my dissertation research on diagnosing patterns. In order to gain data for this study I am in need for students in the counseling master's degree program housed at the University of Alaska Fairbanks who have completed, at least one semester of on-campus practicum experience, but have yet to graduate to participate in this study.

Participants will be shown a scripted, 30-minute video recorded interview with an actor portraying a client coming for service at a local clinic. All participants will, upon completion of the video, be asked to complete an intake form and multi-axial diagnosis of the client, located on UA Google Apps. Please **do not** inform students of the project in its entirety, students will be provided a Participant information sheet, providing them with information approved by the IRB.

Please let me know if you would be willing to offer participation in this study as a portion of your students learning opportunity. Students wishing to participate in this research need to email baniles@alaska.edu

APPENDIX C:

UAA Email to Instructors

My name is Britton Niles. I am an Interdisciplinary Doctoral Candidate, studying multicultural counseling and psychology. I am conducting my dissertation research on diagnosing patterns. In order to gain data for this study I am in need for students in the Counseling Education Master of Education program housed at the University of Alaska Anchorage who have completed, at least one semester of on-campus practicum experience, but have yet to graduate to participate in this study.

Participants will be shown a scripted, 30-minute video recorded interview with an actor portraying a client coming for service at a local clinic. All participants will, upon completion of the video, be asked to complete an intake form and multi-axial diagnosis of the client, located on UA Google Apps. Please **do not** inform students of the project in its entirety, students will be provided a Participant information sheet, providing them with information approved by the IRB.

Please let me know if you would be willing to offer participation in this study as a portion of your students learning opportunity. Students wishing to participate in this research need to email baniles@alaska.edu

APPENDIX D:

APU Email to Instructors

My name is Britton Niles. I am an Interdisciplinary Doctoral Candidate in the School of Education, studying multicultural counseling and psychology. I am conducting my dissertation research on diagnosing patterns. In order to gain data for this study I am in need for students in the Master's of Science in counseling psychology program housed at the Alaska Pacific University who have completed, at least one semester of on-campus practicum experience, but have yet to graduate to participate in this study.

Participants will be shown a scripted, 30-minute video recorded interview with an actor portraying a client coming for service at a local clinic. All participants will, upon completion of the video, be asked to complete an intake form and multi-axial diagnosis of the client, located on UA Google Apps. Please **do not** inform students of the project in its entirety, students will be provided a Participant information sheet, providing them with information approved by the IRB.

Please let me know if you would be willing to offer participation in this study as a portion of your students learning opportunity. Students wishing to participate in this research need to email baniles@alaska.edu

APPENDIX E:

STUDENT EMAIL AND ANNOUNCEMENT FOR COUNSELING

PROGRAM LIST SERVE

GRADUATE STUDENT DISSERTATION

RESEARCH PARTICIPANT OPPORTUNITY

RESEARCH PARTICIPANTS NEEDED

Description: We are asking you to help us by taking part in a brief demographic survey and in watching a 30-minute client interview and filling out an intake form and diagnosis.

While this will not immediately benefit you it **WILL** benefit all of us in the future. I realize how valuable your time is and how busy you are. **PLEASE** complete this study as in doing so it **WILL** help the populations We aim to serve.

To participate email baniles@alaska.edu

THANK YOU!

APPENDIX F:

PARTICIPANT INFORMATION SHEET

Participant Information Sheet

The purpose of participating in this study is to assist in the understanding of diagnosing clients.

Description: We are asking you to help us by taking part in a brief demographic survey and in watching a 30-minute client interview and filling out an intake form and diagnosis.

Benefits and Risks of Participating: We are unable to pay you for your participation. We expect participation will help facilitate knowledge related to mental health diagnosis. While you may not benefit directly from participating, we hope that the knowledge gained will benefit many others. We do not expect any risks from participating. However, some people might experience discomfort from the video. You may choose not to answer any demographic questions that bother you. You can also take breaks as you need. Should you feel uncomfortable, you may choose to stop and not participate at any time.

Voluntary Nature of the Study: Your decision to take part in this study is voluntary. You are free to choose not to take part in this study or to stop taking part at any time without any penalty to you.

Contacts and Questions: If you have questions now, feel free to ask us. If you have questions later, you may contact: Dr. Allan Morotti at any time if you have questions about this study. You can reach him at: University of Alaska Fairbanks Counseling Department, Fairbanks, AK 99775 or by phone at 907-474-6440 or email aamorotti@alaska.edu

APPENDIX G:
VIDEO MENTAL HEALTH SCRIPT

	Mental Health Script	
Client Demographic Questions		
<p>1. <i>Client and Counselor are seated in room</i> (Camera view allows for client to be seen throughout entire session)</p> <p>Building Rapport</p> <p>Explaining Mandated Reporter</p> <p>Confidentiality</p> <p>Mental Status Exam</p>	<p>Counselor: Well hello Mr. Caruk it is nice to meet you. My name is Dr. Yortik I am a counselor here and I understand that you have some concerns that have brought you here to talk with me.</p> <p>Client: Yes.</p> <p>Counselor: Have you ever been in counseling before?</p> <p>Client: No, No I have not.</p> <p>Counselor: ok then before we get started I want to take time to let you know what happens in counseling and specifically during our first appointment together. First I have some kind of regular questions, you know name and age sort of things, then we will have a chance to talk about the reasons you have come to talk with me today. Does that sound all right?</p> <p>Client: Yes, it does.</p>	

	<p>Counselor: OK so one of the benefits of counseling is that what you say here stays here. That means this is a place where you can come and say whatever is on your mind and I cannot tell anyone. That's is called confidentiality. But Jerry there are a few exceptions to this rule, because I am a mandated reporter. What that means is that if I hear anything about abuse or intent to financially, physically, or sexually abuse a child, elders, self or others I am required to report it. I am also required to report any suicidal or homicidal intentions, in order to protect everyone involved. Do you understand the reasons I would have to break confidentiality or do you have any questions about that?</p> <p>Client: I understand. I do not have any questions.</p> <p>Counselor: OK then. To get things started what is your full name?</p> <p>Client: Jerry Caruk.</p> <p>Counselor: I know it sounds funny but are you male or female?</p> <p>Client: I am male.</p> <p>Counselor: How old are you?</p>	
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	<p>Client: 19 years old.</p> <p>Counselor: Can you tell me what year it is?</p> <p>Client: 2010</p> <p>Counselor: Did you have a good New Years?</p> <p>Client: Yeah, I sure did. I sure put a few too many back that night.</p> <p>Counselor: Hmmm. Well, I have a few more questions that may seem funny but then if you would like we could talk more about that.</p> <p>Client: OK.</p> <p>Counselor: Can you tell me where you are right now?</p> <p>Client: Yes, I am at your mental health office, downtown Fairbanks.</p> <p>Counselor: OK now I am going to tell you 3 words and I would like you to remember them and I will ask you</p>	
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	<p>to tell me them in a little while. Do you understand?</p> <p>Client: Yes</p> <p>Counselor: OK the words are: Friendly, Dolphin, Lane</p> <p>Client: Friendly, Dolphin, Lane</p> <p>Counselor: Yes</p> <p>Client: OK</p> <p>Counselor: Can you tell me who the President of the United States is?</p> <p>Client: Obama.</p> <p>Counselor: Can you list as many words that start with the letter R in 1 minute?</p> <p>Client: OK well: Red, Roll, Rate, Rode, Raw, Rip, Run, Rib, Rat, Rhino, Real, Read, Rash</p> <p>Counselor: OK and stop. Now if you find a envelope and it is addressed</p>	
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	<p>and has a stamp, what should you do with the envelope?</p> <p>Client: Um, well I guess put it in the mailbox or give it to a mailman.</p> <p>Counselor: OK. Now I am going to say some numbers to you and I would like you to say them right back to me. Do you understand?</p> <p>Client: Yes.</p> <p>Counselor: OK. 12-5-17-6-34</p> <p>Client: 12-5-17-6-34</p> <p>Counselor: Can you tell me those 3 words I asked you to remember?</p> <p>Client: Yes, um...Friendly, Dolphin Lane.</p> <p>Counselor: Good.</p> <p>Client: Why do you ask me to remember those words?</p> <p>Counselor: That is a way that I</p>	
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	<p>determine if you have any difficulties with memory.</p> <p>Client: Oh, OK.</p> <p>Counselor: This is the last task in this part. Now I am going to point at objects in the room and I would like you to tell me what they are. Do you understand?</p> <p>Client: Yes.</p> <p>Counselor: Lamp, Table, Pen.</p>	
Intake question One		
<ol style="list-style-type: none"> 2. Client is visible on screen. 3. Intake question One 4. Trouble sleeping 5. Anxiety symptoms 6. Relationship Over 7. Tylenol PM use 8. Alcohol Use 9. 	<p>Counselor: OK, Jerry, we are done with the sort of funny questions. Can you tell me why you decided to come in and talk with me today?</p> <p>Client: Yes. Well I have been having some difficulties sleeping. Recently split with my partner. Just my whole life went into the toilet.</p> <p>Counselor: OK so let's start with trouble sleeping. Can you tell me more about that?</p> <p>Client: Yeah. Well it started about 6</p>	

	<p>months ago. I just keep on having difficulties falling asleep and staying asleep.</p> <p>Counselor: Why do you think you have been having difficulty sleeping for the last 6 months?</p> <p>Client: It all started when my girlfriend left me.</p> <p>Counselor: Uh-huh.</p> <p>Client: Um, yeah, well I was in a relationship with this girl Wendy. We have everything in common. And she is really beautiful too. I met her when I came to Fairbanks. She was so great, we met at a bonfire I was at, and right away I knew. I really love Wendy. I miss her so much. When she left I just did not know what to do. I miss her so much. All I do is lay around my house. I am so unhappy.</p> <p>Counselor: It sounds like you miss Wendy very much and it is impacting your sleep.</p> <p>Client: Yes. Before Wendy left sleep was not an issue, but I mean as soon as she left I just started not being able to sleep. I stay up all night watching TV, and I do not even have cable so you know that is rough. But it has</p>	
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	<p>really become a problem. I feel like crap all the time. Mentally I am tired, and I miss Wendy, and because of all of this stuff, that I do not understand. So things got even worse like a month or two ago when I missed work a few times because I could not sleep, but then when I did fall asleep I overslept making me miss work. My boss fired me, which is not fair. It's the Tylenol PMs fault! I tried to explain to him what was going on, but he was just such a jerk about it. He doesn't care no one cares.</p> <p>Counselor: Can you tell me what you mean by Tylenol PMs fault?</p> <p>Client: Yeah, when I started having the trouble sleeping I started to use Tylenol PM to help me fall asleep. I literally had been up and I just could not turn my brain off. So I heard that Tylenol PM can help people and I mean it works too. But the thing is it just makes it so hard to wake up. This stuff knocks me on the floor. I have the craziest dreams.</p> <p>Counselor: Are you currently using any other drugs or alcohol?</p> <p>Client: I drink sometimes, but nothing else too much.</p> <p>Counselor: You drink sometimes.</p>	
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	<p>How much and how often?</p> <p>Client: Yeah, well. That is hard to say, kind of hard to remember, but I don't know like 1-3 times a week.</p> <p>Counselor: Do you mean 1-3 beverages a week or 1-3 sessions of drinking a week?</p> <p>Client: Yeah, that's what I mean.</p> <p>Counselor: I'm still a bit confused. How many alcoholic beverages do you have a week?</p> <p>Client: Um, 5 or 6 I suppose.</p> <p>Counselor: And when you drink those drinks, what types of alcohol is it? Beer, mixed drinks or wine coolers?</p> <p>Client: Definitely not wine coolers. Usually about 2-4 shots of Jack Daniels a week and 2 or 3 beers a week.</p> <p>Counselor: OK and when you drink alcohol do you take the Tylenol PM at the same time?</p>	
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	<p>Client: Not too often.</p> <p>Counselor: So do you take them at the same time 2x per week?</p> <p>Client: Yeah, about that maybe 2 or 3x a week. It makes me fall asleep though.</p> <p>Counselor: OK. So about 6 months ago your girlfriend left and since that time you have been having difficulties sleeping. So you started to use Tylenol PM 2-3xs per week to help with that. Is that right?</p> <p>Client: Yes, and then I got fired cuz the PM works too good.</p> <p>Counselor: Are you working now or looking for work?</p> <p>Client: Well, I should be but I do not like interviewing. I get so sick to my stomach.</p> <p>Counselor: Can you tell me more about being sick to your stomach?</p> <p>Client: Yeah. Well, I am just not so</p>	
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	<p>good at going in and telling people I need a job. It makes me feel like I am begging. I never liked it. Whenever I think about getting a job my hands literally get sweaty, my heart gets all racing, and get all shaky. And that happens like every time I think about interviewing. Last job I got was like a thing I just fell into. It was kind of weird I was at the grocery store and I was on the seasoning isle. Randomly this guy started talking to me and before I knew it he had offered me a job in his restaurant. I got lucky.</p> <p>Counselor: What type of work do you do?</p> <p>Client: I am a cook. I started cooking when I was very small for my family. It was my place.</p> <p>Counselor: Your place?</p> <p>Client: Cooking is the thing I believe I was meant to do. In the beginning I was always drawn to cooking and started creating my own restaurant menu after I got my GED. I really want my own restaurant someday. The truth is I am not good at anything else. Thank God for food. I doubt it will ever work. I feel like puking every time I look at the newspaper for jobs. I just can't even do that. Just thinking about filling out an application makes me have nightmares. I had this dream the other</p>	
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night that I was in a long line. At the front of the line was a man who was handing out jobs. The problem was I knew I only could wait in line a short amount of time (I do not know why I felt that way in the dream, but I did) anyway after I wait in line and am feeling horrible while doing so. I finally make it to the front of the line and there is my dad in the window who is handing out jobs to people. And when he sees me he closes his window. And then I woke up. Figures my dad would be at the window.

Counselor: Very interesting dream. What do you think the dream means?

Client: Well, I do not know for sure. I guess I need a job. I do not know why my dad is in the dream. What do you think the dream means?

Counselor: Sounds like cooking is something that is very important to you. Also, something that you are skilled at doing. Is discussing your nervousness about getting a job something you would like to include in our discussions?

Client: Yeah, I guess I need to, I am out of money, and I need a job. My parents have started hassling me. Yeah and the bill collectors have started calling. And all this hassle just makes me want to do nothing. Nothing at all. I never have liked

	<p>people really. I just figure if you stay home you can avoid them. Which actually kinda works. If no one is around then no one can give you a hard time. Plus I mean how do you even meet people. I just don't think it is worth the difficulty of finding new friends or whatever. I am just a hermit.</p> <p>Counselor: A hermit?</p> <p>Client: Yeah destined to live under a bridge all alone.</p>	
Family History Question		
	<p>Counselor: You mentioned your parents. Can you tell me about your family?</p> <p>Client: Um, sure. Well, my parents live here. I also have a brother, Bill, but we do not talk much, he lives in the Bush. No one else really, I mean that matters. I have a huge extended family, but since we moved to Fairbanks, we don't get to see or talk to them much.</p> <p>Counselor: Your parents live here in Fairbanks then?</p> <p>Client: Yeah, they live here. Let me</p>	

	<p>see there is my Dad, John; he is 57 and a carpenter by trade well now he is since we moved here. And my mom, Barbara, um she stayed home and raised my brother and me. I think she is bored now that we are grown up. Me my mom and dad moved here to Fairbanks about 3 years ago. That is part of the difficulty I think. Since we moved here we have all been living together. They are the ones who said maybe I should come and talk to you.</p> <p>Counselor: Why did your parents think you should come and talk with me?</p> <p>Client: Well, I think my dad would say that I am lazy and need to get off my butt. Well I think that is what he would say. He might say a few other things, I don't know family history... I do not know you would have to ask him. My mom on the other hand is worried. She probably would tell you that she is worried, probably that I am not happy. She worries a lot. Or at least she seems to have always been worried about me. I guess I did not give it to them easy. I was a troubled youth. But who wasn't right? Anyway, that is my parents.</p> <p>Counselor: Do you have a close or tight relationship with your parents?</p> <p>Client: I am real close with my mom.</p>	
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	<p>We see each other a lot and I talk to her. We have always been close, even from when I was young. It was my mom who taught me to cook in the beginning. She always says, "It is the spirit of the chef that nurtures." She is great. My dad not so much. He is sort of different than I am. He does not understand that I want to have my own restaurant. He thinks that it is a stupid pipe dream. It's kind of strange to have parents who have complete opposite views, and I mean extreme.</p> <p>Counselor: So it seems that you and your father have different opinions on what would be a good career for you.</p> <p>Client: Yeah, he just thinks that I should be a different kind of man. He is traditional. In his mind I am weak and lazy. I don't think he has done much either. I mean big deal, all I see is his kids don't like him and his wife should leave him.</p> <p>Counselor: Sounds like you have some difficulties in your relationship with your father and that your mother and you have a relationship that is different and feels accepting.</p> <p>Client: Yeah. Like I said my mom is great. She is my best-friend I guess. I don't really have many friends; I used to hang out with some of the guys I worked with in the last kitchen. Which probably is something that I</p>	
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	<p>should not have done. But since I got fired I don't see them anymore. So I guess since I lost my job and stopped partying with my work friends, my mom and I have become even closer. Wendy my X and I used to hang out too, she did not like my friends though. Wendy is a lot like my mom in that way.</p> <p>Counselor: How long were you in a relationship with Wendy?</p> <p>Client: About 8 months. I think. Let me see yeah about 8 months. I was going to ask her to marry me this coming Valentine's Day.</p> <p>Counselor: Sounds like Wendy was a very important person in your life and that she reminded you a lot of your mom. The ending of your relationship seems to be part of the reason you have experienced difficulties in your life.</p> <p>Client: Yeah, Wendy said that if I did not change she would leave. I do not know what that means, "change" Everything seemed to be going so great. We were talking about getting a place together; I even talked to my parents about moving out of their house. I thought that Wendy and I were going to have kids together. It came out of the blue. One day she was there and the next gone. I mean gone. She disconnected her cell, wont</p>	
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	<p>talk to me when I go by her work, her friends won't even return my calls.</p> <p>Counselor: OK we will spend more time talking about your relationship with Wendy in our next session. I am wondering if you can tell me about your brother. I think you said his name was Bill.</p> <p>Client: Yeah, Bill is kind of a funny guy. He has always been more like my dad and I am more like my mom. We used to play and stuff when we were little kids. But when we got older we started running with different crowds. And over these last 3 years I think we have talked 1 or 2Xs at holidays or something. He lives in the bush so communication isn't as easy.</p> <p>Counselor: He is more like your dad and you are more like your mom?</p> <p>Client: Yeah, Bill is uptight- a by the book kind of person. Where as I don't think it has to be a certain way. He buys into the whole traditional thing. Be a man, work hard blah blah. I am more like my mom you know. Lay low, do my thing.</p>	
Physical Health		

	<p>Counselor: OK, I am going to shift gears and ask you about your physical health. Do you have any physical concerns?</p> <p>Client: No not really. I used to work out but not in months now.</p> <p>Counselor: Did you work out at a gym or what kind of working out where you doing?</p> <p>Client: You know lifting weights and I like running. So I used to go running in the morning and sometimes at night if we were not doing anything.</p> <p>Counselor: Is that something you would like to start doing again?</p> <p>Client: I don't know, I just don't have the energy.</p> <p>Counselor: Are you currently on any prescription medications?</p> <p>Client: No, not now.</p> <p>Counselor: Was there a point when you were on prescription medications?</p>	
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	<p>Client: Yeah, from time to time I have had back pain from a accident I had a few years back. But I have not been using the pain meds for a while.</p> <p>Counselor: So, you only use the painkillers when you have back pain. How often does that occur?</p> <p>Client: Umm..About 1-2 times a week.</p> <p>Counselor: Are you currently using any street drugs?</p> <p>Client: Not really</p> <p>Counselor: Not really?</p> <p>Client: Not for a few years. I'm older now.</p> <p>Counselor: Do you have any family illnesses in your family?</p> <p>Client: Well, I have had a few lung cancer deaths. Smokers ya know. I just never got into smoking so no concerns there. Um, my grandma died from something kind of strange but I</p>	
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	<p>cannot remember what that was. That's about it.</p> <p>Counselor: Do you have any family members that have ever been diagnosed with a mental health diagnosis?</p> <p>Client: Um, yeah, I remember my aunt went to Anchorage once to see a shrink. After that she got lots happier. I think they gave her the happy pills ya know.</p> <p>Counselor: Do you know what she was taking the pills to help with? Well, I guess I do not know the technical terms. But I would say depression. Who is not depressed though?</p>	
Scene 5		
	<p>Counselor: OK that is all of my questions. Is there anything else I should know. That I have not asked?</p> <p>Client: I do not think so. I guess you should know that I do not think that this counseling stuff will work. I think that I might just be one of those people who is stuck.</p> <p>Counselor: Stuck?</p>	

	<p>Client: Yeah. It has just been a sequence of events in my life that seem to lead to me feeling this way.</p> <p>Counselor: Jerry. It seems to me that the fact that you are able to come in here and tell me about your life and difficulties. This suggests that you are a strong person who is willing to work to get your life where you want it to be.</p> <p>Client: I guess so</p> <p>Counselor: I want to thank you for coming in and talking with me. I know how difficult it can be to share yourself in this way. Lets go ahead out to the secretary and set up your next appointment for next week. Does that sound good?</p> <p>Client: Yeah, thanks for talking to me. I hope I wasn't too depressing.</p> <p>Counselor: Not at all I look forward to seeing you next week.</p>	
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APPENDIX H:

Demographic Survey and Adult Intake Form

Participant Information

Please, identify the following information about yourself

Thank you for participating in this research

Male or Female:

Age:

Please watch the 30-minute client session video.

After watching session please complete the intake form and diagnosis on this client.

Type directly on this form.

Adult Intake Form

Client Name:

D.O.B.

Gender:

Client Presentation (Mental Status Exam):

Client Presenting Concerns:

History of Mental Health Treatment:

History:

Family History:

Physical Health:

DIAGNOSIS

AXIS I _____

AXIS II _____

AXIS III _____

AXIS IV _____

AXIS V (GAF Score) _____

APPENDIX I:

296.2x Major Depressive Disorder, Single Episode

- A. Presence of a single Major Depressive Episode.
- B. The Major Depressive Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
- C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode. NOTE: This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition.

If the full criteria are currently met for the Major Depressive Episode, specify its current clinical status and/or features:

Mild, Moderate, Severe Without Psychotic Features/Severe

With Psychotic Features

Chronic

With Catatonic Features

With Melancholic Features

With Atypical Features

With Postpartum Onset (APA, 2000, p. 375).

APPENDIX J:

300.23 Social Phobia

- A. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing.
- B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed Panic Attack.
- C. The person recognizes that the fear is excessive or unreasonable.

- D. The feared social or performance situations are avoided or else are endured with intense anxiety or distress.
- E. The avoidance, anxious anticipation, or distress in the feared social and performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.
- F. In individuals under age 18 years, the duration is at least 6 months.
- G. The fear or avoidance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition and is not better accounted for by another mental disorder (e.g., Panic Disorder With or Without Agoraphobia, Separation Anxiety Disorder, Body Dysmorphic Disorder, a Pervasive Developmental Disorder, or Schizoid Personality Disorder).
- H. If general medical condition or another mental health disorder is present, the fear in Criterion A is unrelated to it, e.g., the fear is not stuttering, trembling in

Parkinson's disease, or exhibiting abnormal eating behavior in Anorexia Nervosa or Bulimia Nervosa.

Specify if: Generalized: if the fears include most social situations (also consider the additional diagnosis of Avoidant Personality Disorder) (APA, 2000, p. 456)

APPENDIX K:

307.42 Primary Insomnia

- A. The predominant complaint is difficulty initiating or maintaining sleep, or nonrestorative sleep, for at least 1 month.
- B. The sleep disturbance (or associated daytime fatigue) causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The sleep disturbance does not occur exclusively during the course of Narcolepsy, Breathing-Related Sleep Disorder, Circadian Rhythm Sleep Disorder, or a Parasomnia.
- D. The disturbance does not occur exclusively during the course of another mental disorder (e.g., Major Depressive Disorder, Generalized Anxiety Disorder, a delirium).

- E. The disturbance is not due to the direct physiological effects of substances (e.g., a drug of abuse, a medication) or a general medical condition. (APA, 2000, p. 604)

APPENDIX L:

291.XX Substance-Induced Mood Disorder

- A. A prominent and persistent disturbance in mood predominates in the clinical picture and is characterized by either (or both) of the following: (1) depressed mood or markedly diminished interest and pleasure in all, or almost all, activities (2) elevated, expansive, or irritable mood
- B. There is evidence from the history, physical examination, or laboratory findings of either (1) or (2):
 - (1) the symptoms in Criterion A developed during, or within a month of, Substance Intoxication or

Withdrawal (2) medication use is etiologically related to the disturbance

- C. The disturbance is not better accounted for by a Mood Disorder that is not substance induced. Evidence that symptoms are better accounted for by a Mood Disorder that is not substance induced might include the following: the symptoms precede the onset of the substance use (or medication use); the symptoms persist for a substantial period of time (e.g., about a month) after the cessation of acute withdrawal or severe intoxication or are substantially in excess of what would be expected given the type or amount of the substances used or the duration of use; or there is other evidence that suggest the existence of an independent non-substance-induced Mood Disorder (e.g., a history of recurrent Major Depressive Episodes).
- D. The disturbance does not occur exclusively during the course of delirium.
- E. The symptoms cause clinically significant distress impairment in social, occupational, or other important areas of functioning.

Note: This diagnosis should be made instead of diagnosis of Substance Intoxication or Substance Withdrawal only when the mood symptoms are in excess of those usually associated with the intoxication or withdrawal syndrome and when the symptoms are sufficient severe to warrant independent clinical attention.

Code (Specific Substance)-Induced Mood Disorder:

291.89 Alcohol, 292.84 Amphetamine; 292.84 Cocaine; 292.84 Hallucinogen; 292.84 Inhalant; 292.84 Opioid; 292.84 Phencyclidine; 292.84 Sedative, Hypnotic, or Anxiolytic; 292.84 Other (or unknown) Substance.

Specify type:

With Depressive Features: if the predominant mood is depressed

With Manic Feature: if the predominant mood is elevated, euphoric, or irritable

With Mixed Features: if symptoms of both mania and depression are present and neither predominates

Specify if:

With onset During Intoxication: if the criteria are met for Intoxication with the substance and the symptoms develop during the intoxication syndrome

With Onset During Withdrawal: if criteria are met for Withdrawal from the substance and the symptoms develop during, or shortly after, a withdrawal syndrome
(APA, 2000, p.409)

APPENDIX M:

309.28 Adjustment Disorder With Mixed Anxiety and Depressed Mood

- A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).
- B. These symptoms or behaviors are clinically significant as evidenced by either of the following: (1) marked distress that is in excess of what would be expected from exposure to the stressor or (2) significant

impairment in social or occupational (academic)
functioning

- C. The stress-related disturbance does not meet the criteria for another specific Axis I disorder and is not merely an exacerbation of preexisting Axis I or Axis II disorder.
- D. The symptoms do not represent Bereavement.
- E. Once the stressor (or its consequence) has terminated, the symptoms do not persist for more than an additional 6 months.

Specify if:

Acute: if the disturbance lasts less than 6 months

Chronic: if the disturbance lasts for 6 months or longer

Subtype:

309.0 With Depressed Mood

309.24 With Anxiety

309.28 With Mixed Anxiety and Depressed Mood

309.3 With Disturbance of Conduct

309.4 With Mixed Disturbance of Emotions and
Conduct

309.9 Unspecified (APA, 2000, p. 683)

APPENDIX N:

300.29 Specific Phobia

- A. A Marked and persistent fear that is excessive or unreasonable cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).
- B. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take

the form of a situationally bound or situationally predisposed Panic Attack.

C. The person recognizes that the fear is excessive or unreasonable.

D. The phobic situation(s) is avoided or else is endured with intense anxiety or distress.

E. The avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with the person's normal routine, occupational or (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.

F. In individuals under the age of 18 years, the duration is at least 6 months.

G. The anxiety, Panic Attacks, avoidance associated with the specific object or situation are not better accounted for by another mental disorder, such as Obsessive Compulsive Disorder (e.g., fear of dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., avoidance of the stimuli associated with the severe stressor), Separation Anxiety Disorder (e.g., avoidance of

school), Social Phobia Disorder (e.g., avoidance of social situations because of fear or embarrassment), Panic Disorder with Agoraphobia, or Agoraphobia Without History of Panic Disorder.

Specify type:

Animal Type

Natural Environment Type

Blood-Injection-Injury Type

Situational Type

Other Type (APA, 2000, p. 449-450)

APPENDIX O:

Substance Abuse

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

1. Recurrent substance use resulting in a failure major role obligations at work, school, or home (e.g., repeated absences or poor work

performance related to substance use;
substance-related absences, suspensions, or
expulsions from school; neglect of children or
household)

2. Recurrent substance use in situations in which it
is physically hazardous (e.g., driving an
automobile or operating a machine when
impaired by substance use)
3. Recurrent substance related legal problems (e.g.,
arrests for substance-related disorderly conduct)
4. Continued substance use despite having
persistent or recurrent social or interpersonal
problems caused or exacerbated by the effect of
the substance (e.g., arguments with spouse
about consequences of intoxication, physical
fights)

B. The symptoms have never met the criteria for Substance
Dependence for this class of substance. (APA, 2000, p. 199)

APPENDIX P:

Global Assessment of Functioning (GAF) Scale

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

100-91 Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.

90-81 Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).

80-71 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in schoolwork).

70-61 Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.

60-51 Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflict with peers or co-workers).

50-41 Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).

40-31 Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such

as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

30-21 Behavior is considerably influence by delusions or hallucinations OR serious impairment in communication and judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).

20-11 Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).

10-1 Persistent danger of hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.

0 Inadequate information. (APA, 2000, p. 34)

APPENDIX Q:

Hays (2009), ten-step process for Cultural Cognitive Behavioral Therapy (CBT):

- (1) Assess the person's and family needs with an emphasis on culturally respectful behavior;
- (2) Identify culturally related strength and supports;
- (3) Clarify what part of the problem is primarily environmental and what part is cognitive with attention to cultural influences;
- (4) Environment based problems, focus on helping the client to make changes that minimize stressors, increase personal strengths

and supports, and build skills for interacting more effectively with the social and physical environment;

(5) Validate client's self-reported experiences of oppression;

(6) Emphasize collaboration over confrontation, with attention to client-therapist differences;

(7) With cognitive restructuring, question the helpfulness of the thought or belief;

(8) Do not challenge cultural beliefs;

(9) Use the client's list of culturally related strengths and supports to develop a list of helpful cognitions to replace the unhelpful ones;

(10) Develop weekly homework assignments with an emphasis on cultural congruence and client direction.

